



## *The Access Agency*

***FINAL FY 2001 GPRA ANNUAL PERFORMANCE PLAN,  
REVISED FINAL FY 2000 PERFORMANCE PLAN  
AND  
FY 1999 GPRA ANNUAL PERFORMANCE REPORT***

**FEBRUARY, 2000**



## HEALTH RESOURCES AND SERVICES ADMINISTRATION

### FINAL FY 2001 GPRA ANNUAL PERFORMANCE PLAN, REVISED FINAL FY 2000 GPRA ANNUAL PERFORMANCE PLAN AND FY 1999 GPRA ANNUAL PERFORMANCE REPORT

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## HEALTH RESOURCES AND SERVICES ADMINISTRATION

### FINAL FY 2001 GPRA ANNUAL PERFORMANCE PLAN, REVISED FINAL FY 2000 GPRA ANNUAL PERFORMANCE PLAN AND FY 1999 GPRA ANNUAL PERFORMANCE REPORT

#### INTRODUCTION

The Health Resources and Services Administration (HRSA) is the lead Federal agency in promoting access to health care services that create and improve the Nation's health. With a statutory emphasis on special needs, underserved, and vulnerable populations, HRSA mobilizes its bureaus, programs, staff and partners to assure access to quality health care.

HRSA is an agency with multiple programs but with a single strategic goal: **Assure 100% access to health care and 0% disparities for all Americans.** We do not rely solely on the HRSA budget or even other Federal funding in our quest to meet our goal. Instead, we work to establish alliances and partnerships with a broad array of organizations ranging from state and local governments to foundations and corporations.

In order to support our goal, HRSA has established four strategies: 1) Eliminate Barriers to Care; 2) Eliminate Health Disparities; 3) Assure Quality of Care; and 4) Improve Public Health and Health Care Systems. Within each of these strategies there are three substrategies to fully implement them. (See Model I under the Part 1, Section 1.1). We have aligned our strategic plan, our Government Performance and Results Act (GPRA) measures, and our budget under these activities. Although our budget and GPRA measures are explicitly tracked to specific appropriate funding lines, our approach to accomplishing our overall strategic goal can be viewed in the context of these cross-cutting strategies.

The GPRA requires Federal agencies to prepare 5-year Strategic Plans setting out long-term goals and objectives, Annual Performance Plans committing to short-term performance goals, and Annual Performance Reports explaining and documenting how effective the Agency's actions have been at achieving the stated goals. HRSA's performance plan has been prepared in the context of both the Department of Health and Human Services (HHS) Strategic Plan and HRSA's own draft strategic plan. A variety of HRSA programs provide direct funding to assure support for and implementation of the budget themes endorsed by the Secretary for the FY 2001 budget process.

*Healthy People 2000/2010* goals and objectives also serve as a foundation for a number of HRSA's performance measures. It should be noted that although HRSA has lead responsibility for several of the objectives contained in *Healthy People 2000/2010*, achievement of the goals represents a national effort in which HRSA partners with other Federal, State, local, and community health entities.

Therefore, performance measures within HRSA's plan have been crafted to reflect the collaborative nature of HRSA's program activities.

Concerning the organization of the Final FY 2001 Performance Plan, Revised Final FY 2000 Performance Plan and FY 1999 Performance Report, the Department, with broad consensus of HHS components, decided to consolidate both the Annual Performance Plan and the Performance Report into the annual budget submission of the Department.

To achieve greater standardization and consistency in HHS performance plans, GPRA representatives throughout HHS developed a standard outline that all HHS components are using in presenting annual performance plans and reports in response to the requirements of the GPRA. The outline effectively constitutes an "order of presentation" of information required by GPRA and OMB for performance plans and reports. The presentation includes three sections: Part I – Agency Context for Performance Measurement; Part II – Program Planning and Assessment; and Appendix to the Performance Plan.

Part II - Program Planning and Assessment, is structured to reflect the overall HRSA program structure. Individual performance plans are included for each significant program activity. Accordingly, there is, in most cases, a direct linkage between budget line items and corresponding performance plans. The plans are grouped by the major headings of: Primary Care, HIV/AIDS Programs, Maternal and Child Health, Health Professions, Office of Special Programs, Rural Health, Telehealth, Family Planning, Health Care Access for the Uninsured and Program Management.

This Final FY 2001 Annual Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report for HRSA sets out specific performance goals for the Agency for FY 2001 and reports on specific performance goals for FY 1999. It builds on the Revised Final FY 1999 and FY 2000 Annual Performance Plan submitted to the Congress in February 1999. It also complements and supports the budget justification material for the Agency's FY 2001 budget request and is an integral part of the overall HRSA budget. Performance goals that do not have FY 99 data yet, they will be indicated in the plan with the date/year in which the data will be available.

The Annual Performance Plan describes HRSA's performance goals, their linkage to longer-term strategic goals and to the budget, and it describes the steps planned and under way to accomplish each goal. The plan also establishes a method and data source for measuring and reporting on each goal. HRSA has attempted to respond to comments on previous versions of the performance plans. We have provided additional information on coordination with other organizations to reflect the full extent of our joint efforts with other federal or nonfederal organizations. We have addressed data issues that have arisen, and continue to work to improve data sources for each individual goal, as well as outline particular data concerns or limitations. Overall, we think this Plan and Performance Report provides information that will be useful in making resource allocation decisions for FY 2001 and beyond.

## **PART I - AGENCY CONTEXT FOR PERFORMANCE MEASUREMENT**

### **1.1 Agency Mission and Long-Term Goals**

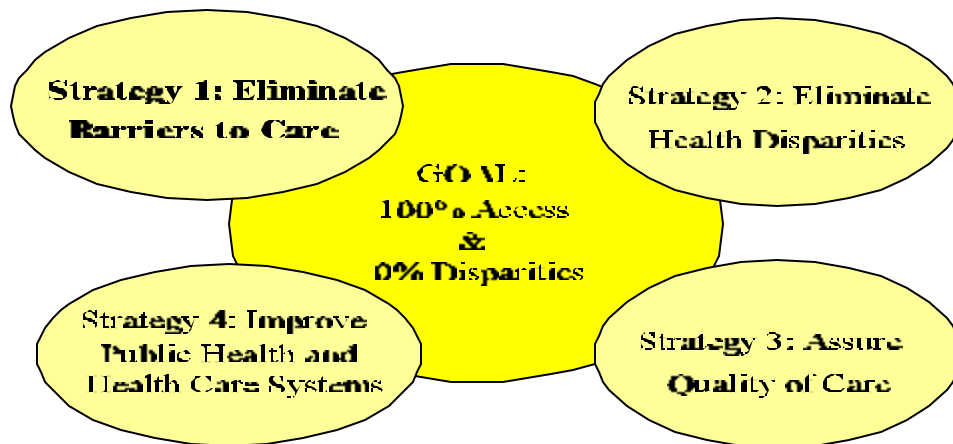
The long-term strategic goal of HRSA is to: Assure 100% access to health care and 0% disparities for all Americans. The overall mission of HRSA to improve the Nation's health by assuring equitable access to comprehensive, quality health care. The HRSA mission statement succinctly states how the organization approaches its responsibilities as the nation's access agency. HRSA accomplishes its mission by:

- C Working with States and communities which form the foundation for developing integrated service systems and the appropriate health workforce to help assure access to essential high-quality health care.
- C Assuring that these systems take into account cultural and linguistic factors, geographic location, and economic circumstances.
- C Assisting States and communities to identify and address unmet service needs and workforce gaps in the health care system.
- C Promoting continuous quality improvement in health services delivery and health professions education.
- C Supporting innovative partnerships to promote effective, integrated systems of care for all population groups.
- C Promoting the recruitment, training, and retention of a culturally and linguistically competent and diverse health care workforce.

Accomplishing the HRSA mission requires setting forth concrete and challenging goals and strategies concerning the reduction and removal of barriers to care and the improvement of the health of the underserved, the vulnerable, and those with special needs. HRSA has completed a strategic planning process which focuses on one overarching goal and four strategies, even beyond the normal five year planning cycle.

The HRSA Strategic Plan identifies four long-range strategies that support HRSA's mission to improve the Nation's health by assuring equitable access to comprehensive, quality health care. Each strategy is supported by strategic objectives that focus on the activities that HRSA will utilize to achieve the strategic goal. These long-range, strategies serve as the performance management framework of the Agency.

# HRSA GOAL AND STRATEGIES



Strategy 1: Eliminate Barriers to Care
<ul style="list-style-type: none"> <li>* Increase utilization for underserved</li> <li>* Increase Access Points</li> <li>* Focus on target population</li> </ul>

Strategy 2: Eliminate Health Disparities
<ul style="list-style-type: none"> <li>* Reduce incidence/prevalence of disease and morbidity/mortality</li> <li>* Increase utilization for underserved populations</li> <li>* Focus on target populations</li> </ul>

Strategy 3: Assure Quality of Care
<ul style="list-style-type: none"> <li>* Promote appropriateness of care</li> <li>* Assure effectiveness of care</li> <li>* Improve customer/patient satisfaction</li> </ul>

Strategy 4: Improve Public Health and Health Care Systems
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- |  |
|--|
| <ul style="list-style-type: none"><li>* Improve Information development and dissemination</li><li>* Promote education and training of the Public Health and Health Care Workforce</li><li>* Promote systems and infrastructure development</li></ul> |
|--|

To best accommodate the linkage of performance goals and measures for program activities to the budget requests for these programs, HRSA incorporated its annual performance goals and measures into the budget submissions for the HRSA Bureaus/Offices that administer the programs. The HRSA Bureaus/Offices FY 2001 Performance Plans and Budgets, both of which are important to understand performance planning in HRSA, contain detailed performance information for HRSA's program activities as required under GPRA. They contain performance goals and measures, the means and strategies that will be used to achieve the goals, data verification and validation, linkage to the bureau/office's budget, and discussions of cross-cutting programs.

HRSA's strategic goal and strategies are designed to be end points, and will require intermediate steps along the way, but they do convey the direction in which the agency is headed. The four strategies are as follows:

#### **STRATEGIC GOAL: 100% Access and 0% Disparities**

**Strategy #1: Eliminate Barriers to Care** - To assure access to comprehensive, timely, culturally competent and appropriate health care services for all underserved, vulnerable and special needs populations. Substrategies include: a) Increase Utilization for Underserved Populations, b) Increase Access Points, and c) Focus on Target Population.

**Strategy #2: Eliminate Health Disparities** - To eliminate disparities in health status and health outcomes for underserved, vulnerable and special needs populations. Substrategies include: a) Reduce Incidence/Prevalence of Disease and Morbidity/Mortality, b) Increase Utilization for Underserved Populations, and c) Focus on Target Population.

**Strategy #3: Assure Quality of Care** - HRSA will assure quality care is provided to the underserved by fostering a diverse, quality work force and the utilization of emerging technologies. Substrategies include: a) Promote Appropriateness of Care, b) Assure Effectiveness of Care, and c) Improve Customer/Patient Satisfaction.

**Strategy #4: Improve Public Health and Health Care Systems** - To improve the ability or capacity to provide health-related services by enhancing the infrastructure of public health and health care systems. Substrategies include: a) Improve Information Development and Dissemination, b) Promote Education and Training of the Public Health and Health Care Workforce, and c) Promote Systems and Infrastructure Development.

The Department of Health and Human Services has developed a final Strategic Plan, which was forwarded to the Congress in September, 1997. The overall HRSA directions and program efforts are consistent with and supportive of the Department goals, which include:

Goal 1: Reduce the major threats to the health and productivity of all Americans.

Goal 2: Improve the economic and social well-being of individuals, families, and communities in the United States.

Goal 3: Improve access to health services and ensure the integrity of the nation's health entitlement and safety net programs.

Goal 4: Improve the quality of health care and human services.

Goal 5: Improve public health systems.

Goal 6: Strengthen the nation's health sciences research enterprise and enhance its productivity.

In appendix A.3, a Table is included which provides illustrative examples of how HRSA performance goals support the Department Strategic Planning goals.

## **1.2 Organization, Programs, Operations, Strategies and Resources**

### **Overview of the Agency**

The Health Resources and Services Administration, an agency of the U.S. Department of Health and Human Services, is the principal Federal agency charged to increase access to basic health care for those who are medically underserved. In Fiscal Year 2000, HRSA put \$4.7 billion to work in programs that add up to access to care for millions of Americans. To fulfill HRSA's important mission, its programmatic portfolio includes a range of programs or initiatives designed to increase access to care, improve quality, and safeguard the health and well-being of the Nation's most vulnerable.

HRSA programs are designed to address problems and issues such as the following:

- C Over 44 million Americans (16.3 percent of the population) did not have private or public health insurance during any part of 1998 (Census Bureau, October, 1999).
- C Nearly 10 million children in the U.S. lack access to health care because of a lack of insurance. The new State Children's Health Insurance Program is designed to reduce that number substantially over the next few years.

- C Nearly 3000 communities across the U.S. do not have an adequate supply of health care providers to meet the basic health needs of the community. Half of these communities are located in rural areas. Most of the rest are poor urban neighborhoods.
- C Even though infant deaths are on the decline, African American infants still are 2.4 times more likely than white infants to die before their first birthday.
- C As of June 30, 1997, more than 612,000 Americans have been reported to have HIV, the virus that causes AIDS.
- C As of Fall, 1999, 66,983 Americans are waiting for an organ transplant.

The approach that HRSA follows is focused on:

#### **Primary Health Care for the Poor, Uninsured and Isolated:**

- C HRSA supports a network of primary care health centers that deliver primary care--preventing disease and treating illness--in underserved areas. Each year, more than 11 million Americans receive care through HRSA health centers. More than half of those receiving care are members of working families with no health insurance. They pay for services on a sliding scale based on their ability to pay. About 40 percent are Medicare or Medicaid beneficiaries.

#### **Health Care for Americans with Special Health Care Needs:**

- C A major HRSA focus is on the health of mothers, children and youth, particularly minority, low-income and uninsured individuals and families who face barriers to needed health services, such as prenatal care and immunization. Through the Maternal and Child Health Block Grant, each State assesses the health care needs of its pregnant women, children and adolescents, then develops and implements a plan to meet them.
- C Ryan White CARE Act programs are designed to help people with HIV/AIDS live better and longer. Funding provides health and support services for under- or uninsured people with HIV/AIDS. The AIDS Drug Assistance Programs are designed to make available the latest therapeutic approaches to care for those who would not otherwise have access to such care.

#### **Training Health Professionals to Serve the Underserved:**

- C HRSA supports a variety of community-based training programs to train the next generation of physicians, nurses and other health professionals to work effectively in managed care, to become productive members of health care teams, and to increase the provision of services in underserved areas.

The primary operating units in HRSA each contribute to this overall mission and major goals and objectives:

**The Bureau of Health Professions**

Mission: To provide national leadership to assure a health professions workforce that meets the health care needs of the public.

**The Bureau of Primary Health Care**

Mission: To increase access to comprehensive primary and preventive health care and to improve the health status of underserved and vulnerable populations.

**The HIV/AIDS Bureau**

Mission: To provide leadership in the delivery of high quality HIV primary care and supporting services for uninsured and underinsured individuals and families affected by HIV/AIDS.

**The Maternal and Child Health Bureau**

Mission: To work on behalf of America's mothers, children, and families in ways that will assure continued improvement in their health, safety, and well-being.

**The Office of Rural Health Policy**

Mission: To be the leading Federal proponent for better rural health care services.

**The Office of Special Programs**

Mission: To ensure access and capacity to scarce resources, such as through organ transplant programs.

**The Office for the Advancement of Telehealth**

Mission: To coordinate HRSA's telehealth activities, such as the use of electronic telecommunications technologies to support long-distance clinical health care, patient and professional health-related education and health administration.

**Operations, Strategies and Resources**

**Internal Resources:**

HRSA will draw upon its current range of resources in order to carry out its mission, but in addition will reinvest in levels of public health training that will produce the required competencies in areas such as surveillance, performance measurement, and systems analysis. As the agency in DHHS that is looked to

for information about the size, scope of, and barriers confronted by the underserved, vulnerable, and special needs populations, those competencies will become increasingly necessary.

Collaboration with the several DHHS and other Federal agencies will continue to be a way of doing business. Sharing resources in the areas of data and information is becoming more common but will need to be more operationalized in the future. Cooperative agreements and work teams on cross-cutting issues will be expected and monitored.

### **External Resources and Partnerships:**

A major source of the Agency's strength is in the linkages and partnerships that have been formed with a variety of grantees and external partners. Initial work has been done toward establishing new working relationships and agreements with outside organizations, with a renewed emphasis on building partnerships with such emerging groups such as the "Coalition for Healthy Communities, Healthy Cities." More training and professional skills development in the areas of leadership and facilitating change will be needed.

HRSA will need to assure that programs are designed to meet the needs of the underserved and that these programs receive sufficiently high priority as Federal and State budget decisions are made. This will require new and innovative efforts to expand many current activities in order to improve program synergy. HRSA will need to leverage existing resources, work more creatively with established partners, and plan closely with new partners at the community, State and Federal level to assure the highest degree of coverage possible for the populations-at-need.

To assure that health centers, State and local health departments, and other HRSA-supported community providers are adjusting to the changes in the health care marketplace, substantial training and technical assistance need to be made available in many areas, but especially in the areas of managed care, contract negotiations, rate setting, medical management, and utilization review.

### **Overall Resource Enhancement**

Additional resources will be needed to carry out the strategic plan, to focus on the human resources required, and to provide leadership with the skills to make full use of the currently available technology. It is essential to invest sufficient resources to maintain a well-trained group of professionals who can assure the accomplishment of the agency's ambitious agenda.

### **1.3 Partnerships and Coordination**

A major source of the Agency's strength is in the linkages and partnerships that have been formed with a variety of Federal and external partners. Collaboration with the several DHHS and other Federal agencies will continue to be a way of doing business. During development of the HRSA performance plan, each Bureau or Office consulted with customer groups to finalize their measures and reach agreements on data collection and reporting for the measures. HRSA is forming new linkages with our Federal partners such as:

HRSA has conducted outreach efforts to ACF, CDC, SAMHSA and HCFA to begin coordination and development of “common measures” for programs that serve similar or shared populations. This work will be conducted over the next twelve months in an effort to eliminate duplicate reporting requirements on grantees and streamline data collection.

HRSA, CDC and HCFA issued a “Letter of Agreement” to State Medicaid directors, State health officials, and various program directors, encouraging the sharing of data across the various programs within each agency. We are now working with willing state partners that have come forward to provide technical assistance to operationalize this agreement. We will conduct some regional meetings during the next twelve months to showcase “Models That Work” for data sharing.

HRSA and HCFA are jointly implementing the Children’s Health Initiative, with a particular focus on the new State Children’s Health Insurance Program. Additional efforts are aimed at improving data sharing and coordination, particularly with the Medicaid program.

HRSA is working with SAMHSA to integrate behavioral health/substance abuse screening, early intervention, referral and follow-up into primary health care settings funded through HRSA grants. This is in recognition that depression, alcohol abuse, and interpersonal violence are among the most prevalent problems challenging the health, both physical and mental, of Americans today. As this initiative moves forward, joint performance measures will be developed with SAMHSA.

HRSA has also explored with USDA, Food and Nutrition Services, opportunities for data sharing and program coordination within our MCH program and their WIC program. After preliminary discussions, we learned that USDA information systems are limited for the most part to eligibility/participant reporting and they can benefit from data collected by our MCH program. Further work is forthcoming in this area, including the opportunity to develop standard data/communication systems architecture to increase data sharing and maximize use of federal dollars supporting system hardware.

HRSA’s and CDC’s partnership efforts are focused on a variety of disease prevention and health promotion activities, including immunization efforts and improved data collection and analysis.

A major source of the Agency’s strength is the linkage and partnerships that have been formed with a variety of grantees and external partners, such as:

- State and local governments through such programs as the Maternal and Child Health Block Grant and Ryan White programs.
- Non-profit health organizations such as the Community and Migrant Health Centers.
- Academic institutions, such as the variety of partners working on health professions issues.

- Foundations, such as the Robert Wood Johnson Foundation, the Kellogg Foundation, and the Kaiser Family Foundation.
- National associations, such as those representing State and local public health departments and groups of primary care providers.
- Business groups such as the Washington Business Group on Health.
- National Academy of Public Administration Performance Consortium and Health Group.

Substantial work has been done toward establishing new working relationships and agreements with such outside organizations. HRSA will continue to need to receive State, local and non-profit input to help assure that programs are designed to meet the needs of the underserved. The agency will need to leverage existing resources, work more creatively with established partners, and plan closely with new partners at all levels to assure the highest degree of coverage possible for the populations-at-need.

#### **1.4 Summary FY 1999 Performance Report: Accountability through Performance Measurement**

HRSA has made a strong effort to build a performance management approach into the way it conducts its business. The agency structured the development of its internal strategic planning process to be consistent with the requirements of the Government Performance and Results Act (GPRA). The goals developed in the process have guided the development of our Annual Performance Plans.

HRSA initiated its GPRA performance measurement effort with an assessment of all programs and their readiness for measuring performance, beginning with the GPRA requirements as the basis for the review. The Agency, using each major program budget line:

- C Identified both strengths and weaknesses in terms of ability to measure performance.
- C Assessed the current availability of indicators and data that can be used to ensure effective management of resources.
- C Identified key areas where developmental activities are needed and have channeled agency resources to these areas.

Technical assistance has been provided to each of the operating components to enhance their ability to define performance goals and measures.

The agency has made a significant contribution to solving the problems identified as areas of responsibility. Improving access to care for the underserved, expanding access to care for women and children, improving

the geographic and specialty distribution of health professionals, and improving the range of care options for people living with HIV, are all targets that HRSA has addressed and continues to address as we move into the next century.

**Access for the Underserved:** Access to health care for low income, underserved and minority Americans continues to be a problem. Currently, some 43 million underserved persons reside in designated rural and inner city underserved areas. HRSA's Health Centers and the National Health Service Corps (NHSC) programs serve 11 million of these people (25 percent) in more than 4,000 communities across the Nation.

Another indicator of both an access problem and a HRSA contribution to helping solve that problem relates to the growing uninsured population. In 1998, some 44.3 million people lacked health insurance, of whom more than 11 million were low income. The numbers of uninsured nationally have grown at a rate of 100,000 per month since 1994. The Health Centers/NHSC programs serve 4.1 million uninsured persons, of whom more than 2 million are children. This is a 50 percent increase since 1990.

Although inadequate access to health care is a serious national problem, there is no single solution. In addition to cost, there are obstacles such as geographic barriers, cultural barriers, and structural difficulties that need to be addressed. For that reason, HRSA works hand-in-glove with State and local organizations to create health care systems that respond to the specific needs of people in the community they serve.

Underserved and low income individuals rely on HRSA Health Centers for the full range of preventive and primary care services, including mental health and substance abuse treatment, case management, referrals to and oversight of specialty and inpatient care, and services that help them use health care services most effectively. Health Centers not only improve the health of underserved individuals, but also the well-being of the communities in which they live. They stimulate education and the neighborhood economy. They are a significant force to quell the public health threats of the 90's - violence, child abuse and neglect, substance abuse, and other causes of premature disability and death.

**Women and Children:** The health of mothers and children is a primary target for HRSA's programs. The Maternal and Child Health Block Grant is the only Federal program that focuses on improving the health of all mothers, adolescents and children, whether insured or not, through a broad array of public health and community-based programs that are designed and carried out through well-established Federal-State-partnerships. State Title V programs support capacity and infrastructure building, population-based and enabling services, as well as direct health care services where no services are available. In these latter roles, Title V programs serve as a safety net for uninsured and underinsured children.

Both the Maternal and Child Health Program and the Health Centers, in cooperation with HCFA, are conducting outreach efforts to enroll children in the State Children's Health Insurance Program (SCHIP). The program has successfully covered over two million children in the first full year of operation. There are problems in some States, however, that as children are enrolled in CHIP, the number enrolled in Medicaid is declining. In these situations, the Title V programs often see an increase in their safety net functions.

Between 1995 and 1997, the number of children served under Title V rose from 11.3 million to 19.4 million children, an increase of 8.1 million children.

One measure of long term progress and success in the health care system is the continuing decline in the infant mortality rate. From 1990 to 1997, the U.S. infant mortality rate declined by more than 22 percent, from 9.2 to 7.1 deaths per 1,000 live births. Programs such as the Maternal and Child Health Block Grant, the Health Centers program, and the Healthy Start Initiative have all contributed to this decline. An important factor in this progress is the receipt of early and quality prenatal care for low income, minority and underserved pregnant women. In 1997, the proportion of pregnant women across the Nation receiving prenatal care in the first trimester reached 82.5 percent. Despite these successes, problems still remain. The infant mortality rate for African Americans is still approximately twice the white rate.

Another area that seems to be showing some signs of improvement is the rate of teenage pregnancy. After years of increases, the teen birth rate declined 12 percent between 1991 and 1996, according to the Centers for Disease Control and Prevention. The proportion of students who had sexual intercourse also fell 11 percent during the 1990's. Despite these recent declines, teen pregnancy and out-of-wedlock sexual activity remain a significant problem in communities across the country. Programs such as the Maternal and Child Health program and the Abstinence Education Program are designed to help continue favorable trends.

**Health Professions :** HRSA programs are designed to promote having health professionals in areas where they are most needed -- in underserved areas. Strategies used by the Health Professions programs for solving the current maldistribution problem and thus improving access to health care include:

- C providing institutional incentives to health professions schools with a good track record for placing their graduates in underserved areas;
- C increasing the number of health care and public health providers from minority and disadvantaged backgrounds;
- C fostering community-based education and training especially in underserved areas;
- C supporting training that is directed at the special needs of vulnerable, underserved populations; and
- C enhancing services to underserved populations.

The health professions programs aggressively address the issue of access to health care. Availability of an adequate staff of health professionals in underserved areas is a critical and often overlooked issue. While efforts are underway to improve the insurance coverage issue through programs such as Medicaid and CHIP, a problem remains if there is no qualified health care professional available and willing to provide health care. The availability of an adequate staff of qualified, culturally competent health care professionals is equally important. Health professions graduates of HRSA programs are three to six times more likely to practice in underserved areas than those in programs not supported by HRSA.

HRSA programs are also directed toward increasing the numbers of minorities in the health professions. The emphasis on minorities serves two major purposes. First, it contributes to moving minorities into the health professions in concert with their representation in the population. Although underrepresented minorities make up nearly 25 percent of the U.S. population, they only account for 10 percent of all health professionals.

Second, data show conclusively that minority health professionals tend to practice in areas where there is inadequate access to health care. Thus, the minority emphasis in HRSA programs not only serves to improve representation in the workforce, but is a major factor contributing to solving the access to health care problem. Graduates of HRSA's Bureau of Health Professions Training Programs are two to three times more likely to be underrepresented minority health professionals, than graduates of those programs not supported by HRSA.

**Expanding Care Options for the HIV Population:** Through the Ryan White CARE Act, an estimated 350,000 people each year have access to services and treatments to keep the human immunodeficiency virus at bay and enable them to live - not just survive. Early in the AIDS epidemic, it became clear that the virus spread faster in some places than in others. In those areas, health care systems were overwhelmed by the number of people needing treatment for HIV/AIDS. Today, approximately 75 percent of people living with AIDS reside in these hardest hit areas. Through Title I of the CARE Act, HRSA is sharing the burden with these Eligible Metropolitan Areas.

Under Title II of the CARE Act, funds are provided to States to improve access to health care and support services. These funds support a range of services, help keep health insurance in place, and pay for medications. Through State AIDS Drug Assistance Programs (ADAP), medications are provided to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid.

One of the most effective treatments for HIV-positive individuals has been appropriate antiretroviral therapy. Individuals who have access to the most appropriate mix of pharmaceuticals have shown significant decreases in mortality and morbidity. The impact of new combination drug therapies was first reported in 1997 when AIDS deaths dropped for the first time. The national death rate from AIDS dropped 42 percent from 1996 to 1997. It then declined 20 percent between 1997 and 1998. Funding from the ADAP program has contributed significantly to the availability of such pharmaceuticals. The performance plan for FY 2001 includes a goal to increase the number of ADAP clients receiving appropriate antiretroviral therapy to a projected monthly average of over 74,000. Given the efficacy of these drug treatments, this expenditure and proposed increase have very high payoffs.

**Organ Procurement and Transplantation:** Another area of significant progress has to do with organ procurement and transplantation. The total number of organ transplants increased 60 percent between 1988 and 1998, but the number of transplant candidates is rising faster than the number of donors. In 1997, the Department launched the National Organ and Tissue Donation Initiative to address the need for increasing organ and tissue donations in both the public and private sectors of the country. 1998 data show

5,799 donors, up about 6 percent from the year before. This is not enough to keep up with the need for organs, since 1999 data show 66,983 registrants waiting for organs. The National Initiative has resulted in more people hearing about the need for organ and tissue donation and more people responding with the gift of life. There will need to be a concerted effort in order to move toward keeping up with the need for organs.

**Rural Health:** About half of the medically underserved live in rural America. Some are poor and uninsured, but many have inadequate access to care for the simple reason that not enough health professionals and clinics are close enough to meet their routine and urgent care needs. Rural health outreach programs are designed to address some of these problems, while State Offices of Rural Health provide a focal point within each State for identifying and addressing rural health issues. HRSA's rural health community health centers and clinics and National Health Service Corps providers are placed in some of the most difficult to serve areas.

**Telehealth:** To bridge gaps of time and distance that separate individuals and families from needed health care, HRSA promotes telehealth -- the use of electronic information and telecommunications technologies to diagnose and treat patients. As technology becomes more widespread and more sophisticated, HRSA expects telehealth to bridge health care gaps in both rural regions and urban areas.

### **Key External Factors That May Affect Plan**

The HRSA Performance Plan has been developed during a period of rapid change in health care. Some of the key factors that will affect the agency plan are as follows:

- C   Racial Disparities:** Low income and minority populations continue to experience significant gaps or disparities in health status that are associated with higher incidences of morbidity and mortality. Financial barriers, geographic distances, cultural distinctions, and provider shortages contribute to these disparities. African Americans and Hispanics are 2.5 times as likely as Whites to have diabetes. African American women are more likely to be in advanced stages of breast cancer. Minority and low income individuals are disproportionately more likely to succumb from asthma, poor pregnancy outcomes, coronary heart disease, stroke, and high blood pressure before a diagnosis is made. Programs such as the Health Centers program, 65 percent of whose patients are from disadvantaged racial/ethnic groups, have an established record of helping to reduce such health disparities.
- C   Dominance of Managed Care:** As we move into an era where the majority of our Nation is enrolled in managed care plans, cost containment pressures will most likely continue to influence patient access to and the delivery of health care services. Nearly every State now relies on some form of Medicaid managed care, and enrollment has grown substantially. To ensure that underserved, vulnerable, and special needs populations (especially those without health care insurance) have continued and increased access to needed services, HRSA must work with its network of providers to gain the capacity to

meet new financial and operating requirements needed to sustain the provision of care to these populations in a managed care environment.

- C The Number of Uninsured:** The lack of insurance coverage will continue to be a major influence in the shaping of the Agency’s future. The increase in the number of uninsured is not expected to abate for certain segments of the population. As a result, more of the poor will become reliant on health care provided by HRSA-funded providers.
- C Aging Population:** Worldwide, we will be experiencing the effects of the profound aging of the overall population, a foretaste of the coming needs of the aging “baby boom” generation. Mortality rates have decreased, increasing the probability of living into one’s eighties. The magnitude of this demographic change will require new and different approaches to the organization and delivery of care.
- C Changing Health Care Workforce:** The current paradigm for the health care workforce appears to be shifting and will continue to change over the next few years. The demand for an inter-disciplinary trained health professions workforce along with the emergence of new types of health care workers (e.g., wellness/health coaches and visiting home health care teams with cross-disciplinary training) will require new approaches to training health care providers and to the delivery of health care.
- C Technological Advances:** Rapid developments in telecommunications, including the transmission of medical data, training, and interpersonal communication is revolutionizing the health industry.

### **Performance Goals within the Structure of Overall HRSA Strategies**

The matrix below provides a sample of the way in which the HRSA performance goals are presented in this Annual Performance Plan. Individual performance goals are supportive of one of the four HRSA strategies:

- I. Eliminate Barriers to Care
- II. Eliminate Health Disparities
- III. Assure Quality of Care
- IV. Improve Public Health and Health Care Systems

Each goal is also placed within one of the subsets of these four strategies.

## Sample of HRSA Performance Goals Supportive of 4 Strategies

### FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report

**Program Title: “Sample of HRSA Measures”**

Performance Goals	Targets	Actual Performance	Reference
<b>I. ELIMINATE BARRIERS TO CARE</b> <b>A. Increase Utilization for Underserved Populations</b> Health Centers: Increase the number of uninsured and underserved persons served by Health Centers, with emphasis on areas with high proportions of uninsured children to help implement the SCHIP program. (2.1)	FY 01: 9.7M FY 00: 9.6M FY 99: 8.9M	FY 01: FY 00: FY 99: 9.15M est.(5/00) (Date when the data will be available) FY 98: 8.7M FY 97: 8.3M	B101
<b>B. Increase Access Points</b> Health Centers/National Health Service Corps: Increase the percent of NHSC clinicians retained in service to the underserved. (2.1)	FY 01: 75% FY 00: 74% FY 99: 72%	FY 01: FY 00: FY 99: (5/00) FY 98: 70.4%	B121
<b>C. Focus on Target Population</b> Family Planning: Increase the number of individuals served by Family Planning-Title X clinics. (2.31)	FY 01: 5.75M FY 00: 5.25M FY 99: 6.0M	FY 01: FY 00: FY 99: 5.0M est. (11/00) FY 98: 4.283M FY 97: 4.362M	B244

Performance Goals	Targets	Actual Performance	Reference
<b>II. ELIMINATE HEALTH DISPARITIES</b> A. Reduce Incidence/Prevalence of Disease and Morbidity/Mortality Maternal and Child Health Block Grant: Decrease the ratio of the black infant mortality rate to the white infant mortality rate. (2.12)	FY 01: 2.1 to 1 FY 00: FY 99:	FY 01: FY 00: FY 99: (9/01) FY 96: 2.4 to 1	B195   HP-14
<b>B. Increase Utilization for Underserved Populations</b> Ryan White CARE Act: Increase the number of ADAP clients receiving appropriate antiretroviral therapy (consistent with clinical guidelines) through State ADAPs during at least one month of the year. (2.7)	FY 01: 74,800 clients* FY 00: 71,900* FY 99: 78,088  *Targets revised based on performance of 64,500 clients for FY 99	FY 01: FY 00: FY 99: 64,500 clients FY 98: 55,000 clients	B212
<b>III. ASSURE QUALITY OF CARE</b> <b>A. Appropriateness of Care</b> Health Centers: Decrease proportion of Health Center users who are hospitalized for potentially avoidable conditions. (2.1)	BPHC FY 01: 13 FY 00: 13.5 FY 99: 14	FY 99: 9/01 FY 98: 9/00 FY 97: 14.7/1000  Norm: 18.9/1000	B101
<b>B. Assure Effectiveness of Care</b> Ryan White CARE Act: Decrease 5 percent in FY 01 the number of newly reported AIDS cases in children as a result of perinatal transmission (2.9)	FY 01: 193*cases FY 00: 203* FY 99: 214* Target measures revised based on revised data to measure performance.	FY 01: FY 00: FY 99: 1/01 FY 98: 225* FY 97: 310* FY 96: 502 *cases *Data used to measure actual performance were revised	B218

Performance Goals	Targets	Actual Performance	Reference
<p>C. Improve Customer/Patient Satisfaction</p> <p>1. Federal Occupational Health - Improve total customer satisfaction among Federal agencies served. (2.5)</p>	<p>FY 01: 95% satisfied</p> <p>FY 00: 95%</p> <p>FY 99: 90%</p>	<p>FY 01:</p> <p>FY 00:</p> <p>FY 99: 2/00</p> <p>FY 98: 85%</p> <p>FY 97: Baseline 78% average satisfaction rate</p>	Off Budget
<p><b>IV: IMPROVE PUBLIC HEALTH AND HEALTH CARE SYSTEMS</b></p> <p><b>A. Improve Information Development and Dissemination.</b></p> <p>Telehealth - Increase the percent of HRSA grantees that are electronically linked to HRSA. (2.30)</p>	<p>FY 01: 65%</p> <p>FY 00: 50%</p> <p>FY 99: 35%</p>	<p>FY 01: (1/02)</p> <p>FY 00: (1/01)</p> <p>FY 99: 30% .</p>	B237
<p><b>B. Promote Education and Training of the Public Health and Health Care Workforce</b></p> <p>AIDS Education and Training Centers: Increase the number of minority health care and social service providers who receive training in AETCs. (2.10)</p>	<p>FY 01: 127,000 trained</p> <p>FY 00: 117,000</p> <p>FY 99: 107,582</p>	<p>FY 01:</p> <p>FY 00:</p> <p>FY 99: 1/01</p> <p>FY 98: 89,549 trained</p> <p>FY 97: 88,817 trained</p>	B221

Performance Goals	Targets	Actual Performance	Reference
<b>C. Promote Systems and Infrastructure Development</b> Emergency Medical Services for Children - Increase the number of States that require all EMSC-recommended pediatric equipment on Advanced Life Support ambulances. (2.14)	FY 01: 23 States FY 00: 10 FY 99: 7	FY 01: FY 00: FY 99: 18 FY 98: 5 States	B205
<b>Total Funding:</b>	FY 2001: \$4.7 billion FY 2000: \$4.6 billion FY 1999: \$4.2 billion FY 1998: \$3.6 billion	B x: page # budget HP: Healthy People goal	

## **PART II - PROGRAM PLANNING AND ASSESSMENT**

### **Introduction**

HRSA has organized its Annual Performance Plan to reflect its overall program structure. Individual performance plans are included for each significant program activity. Accordingly, there is, in most cases, a direct linkage between budget line items and corresponding performance plans. The plans are grouped by the major headings of:

- C Primary Care
- C HIV/AIDS Programs
- C Maternal and Child Health
- C Health Professions
- C Office of Special Programs
- C Rural Health
- C Telehealth
- C Family Planning
- C Health Care Access for the Uninsured
- C Program Management

The aggregation of specific programs within these major headings is shown below.

### **AGGREGATION OF PROGRAM ACTIVITIES IN ANNUAL PERFORMANCE PLANS**

#### **Primary Care**

- 2.1 Health Centers/National Health Service Corps
- 2.2 Black Lung Clinics
- 2.3 National Hansen's Disease Program Activities
- 2.4 Nursing Loan Repayment
- 2.5 Federal Occupational Health

#### **HIV/AIDS Programs**

- 2.6 AIDS: HIV Emergency Relief Grants (Part A)
- 2.7 AIDS: HIV Care Grants to States (Part B)
- 2.8 AIDS: HIV Early Intervention Services (Part C)
- 2.9 AIDS: HIV Pediatric Grants
- 2.10 AIDS Education and Training Centers

## 2.11 AIDS: Dental Services Program

### Maternal and Child Health

#### 2.12 Maternal and Child Health Block Grant - Title V

##### 2.12a Healthy Start Initiative

##### 2.12b Traumatic Brain Injury

#### 2.13 Universal Newborn Hearing Screening and Early Intervention

#### 2.14 Emergency Medical Services for Children

#### 2.15 Poison Control Centers

#### 2.16 Abstinence Education Program - Title V

### Health Professions

#### 2.17 Health Professions and Nursing Training Programs

#### 2.18 Workforce Information and Analysis

#### 2.19 Children's Hospitals Graduate Medical Education Program

#### 2.20 Health Education and Assistance Loans (HEAL) Program

#### 2.21 National Practitioner Data Bank

#### 2.22 Vaccine Injury Compensation Program

#### 2.23 Ricky Ray Hemophilia Relief Fund Program

### Office of Special Programs

#### 2.24 Organ Procurement and Transplantation

#### 2.25 National Bone Marrow Donor Program

### Rural Health

#### 2.26 Rural Health Outreach

#### 2.27 Rural Health Policy Development

#### 2.28 Rural Hospital Flexibility Grants

#### 2.29 State Offices of Rural Health

#### 2.30 Telehealth (Office for the Advancement of Telehealth)

#### 2.31 Family Planning

#### 2.32 Health Care Access for the Uninsured

#### 2.33 Program Management

## **PRIMARY CARE**

### **FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report:**

The mission of the Bureau of Primary Health Care (BPHC) is to increase access to primary and preventive care and to improve the health status of underserved and vulnerable populations. BPHC seeks to meet its mission through the development and support of systems and providers of high quality, community based, culturally competent care. There is mounting evidence that access to a usual and regular source of such care can reduce and even eliminate health status disparities among subsets of the Nation's population. Targeted populations include the uninsured, underinsured, underserved, low income, women and children, homeless persons, migrant farm workers and people in frontier and rural areas. Through its programs, BPHC assists communities in addressing the needs of these populations, who are particularly at risk for poor health outcomes, and builds broader primary care capacity through partnerships with States and localities. Over 11 million of the Nation's neediest people receive care through BPHC programs emphasizing prevention, early detection and timely intervention in approximately 4000 communities.

Programs included in this section are:

- 2.1 Health Centers and the National Health Service Corps
- 2.2 Black Lung Clinics
- 2.3 National Hansen's Disease Program
- 2.4 Nursing Education Loan Repayment
- 2.5 Federal Occupational Health Program

**FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report:**

**2.1 Program Title: Health Centers and the National Health Service Corps**

Performance Goals	Targets	Actual Performance	Reference																						
<b>I. ELIMINATE BARRIERS TO CARE</b> <b>A. Increase Utilization</b> 1. Increase the number of uninsured and underserved persons served by Health Centers, with emphasis on areas with high proportions of uninsured children to help implement the SCHIP program.	FY 01: 9.7M FY 00: 9.6M FY 99: 8.9M	FY 01: FY 00: FY 99: 5/00 (9.15M est.) FY 98: 8.7M FY 97: 8.3M	B101																						
<b>B. Increase Access Points</b> 1. Increase the field strength of the National Health Service Corps through scholarships and loan repayment agreements.	<table><tr><th colspan="2">Unduplicated</th></tr><tr><th>Field</th><th>Users</th></tr><tr><td>FY 01: 2,691</td><td>2.3M</td></tr><tr><td>FY 00: 2,697</td><td>2.3M</td></tr><tr><td>FY 99: 2,526</td><td>2.1M</td></tr></table>	Unduplicated		Field	Users	FY 01: 2,691	2.3M	FY 00: 2,697	2.3M	FY 99: 2,526	2.1M	<table><tr><th colspan="2">Unduplicated</th></tr><tr><th>Field</th><th>Users</th></tr><tr><td>FY 01:</td><td></td></tr><tr><td>FY 00:</td><td></td></tr><tr><td>FY 99: (5/00)</td><td></td></tr><tr><td>FY 98: 2,439</td><td>2.0M</td></tr></table>	Unduplicated		Field	Users	FY 01:		FY 00:		FY 99: (5/00)		FY 98: 2,439	2.0M	B121
Unduplicated																									
Field	Users																								
FY 01: 2,691	2.3M																								
FY 00: 2,697	2.3M																								
FY 99: 2,526	2.1M																								
Unduplicated																									
Field	Users																								
FY 01:																									
FY 00:																									
FY 99: (5/00)																									
FY 98: 2,439	2.0M																								
2. Increase the percent of NHSC clinicians retained in service to the underserved	FY 01: 75% FY 00: 74% FY 99: 72%	FY 01: FY 00: FY 99: (5/00) FY 98: 70.4%	B121																						
<b>C. Focus on Target Population</b> 1. Assure access to preventive and primary care for low income individuals (i.e., at or below 200 % of poverty).	<table><tr><th colspan="3">Unduplicated Users</th></tr><tr><th>HC</th><th colspan="2">NHSC</th></tr><tr><td>FY 01: 86%</td><td>8.26M</td><td>2.0M</td></tr><tr><td>FY 00: 86%</td><td>8.26M</td><td>2.0M</td></tr><tr><td>FY 99: 86%</td><td>7.65M</td><td>1.8M</td></tr></table>	Unduplicated Users			HC	NHSC		FY 01: 86%	8.26M	2.0M	FY 00: 86%	8.26M	2.0M	FY 99: 86%	7.65M	1.8M	FY 01: FY 00: FY 99: 5/00(HC&NHSC) FY 98: 86% (UDS/HC) FY 97: 86% (UDS/HC)	B101							
Unduplicated Users																									
HC	NHSC																								
FY 01: 86%	8.26M	2.0M																							
FY 00: 86%	8.26M	2.0M																							
FY 99: 86%	7.65M	1.8M																							

Performance Goals	Targets	Actual Performance	Reference
2. Assure access to preventive and primary care for minority individuals (racial minorities or of Hispanic origin).	<p style="text-align: center;"><b>Unduplicated Users</b></p> <p style="text-align: center;"><b>HC    NHSC</b></p> <p>FY 01: 65%   6.24M   1.5M</p> <p>FY 00: 65%   6.24M   1.5M</p> <p>FY 99: 65%   5.79M   1.4M</p>	<p>FY 01:</p> <p>FY 00:</p> <p>FY 99: 5/00(HC&amp;NHSC)</p> <p>FY 98: 64% (UDS/HC)</p> <p>FY 97: 65% (UDS/HC)</p>	B101
3. Assure access to preventive and primary care for uninsured individuals.	<p style="text-align: center;"><b>Unduplicated Users</b></p> <p style="text-align: center;"><b>HC    NHSC</b></p> <p>FY 01: 45%   4.37M   1.0M</p> <p>FY 00: 43%   4.10M   .99M</p> <p>FY 99: 42%   3.80M   .88M</p>	<p>FY 01:</p> <p>FY 00:</p> <p>FY 99: (5/00)</p> <p>FY 98: 41% 3.52M</p> <p>FY 97: 39% (HC)</p>	B101
<p><b>II. ELIMINATE HEALTH DISPARITIES</b></p> <p><b>A. Utilization of Services</b></p> <p>1. Increase percent of users with diabetes with up-to-date testing of glycohemoglobin <b>B</b> % adults with diabetes tested at recommend intervals</p>	<p>FY 01: 90%</p> <p>FY 00: 80%</p> <p>FY 99: 60%*</p> <p>*Diabetes initiative at 90% for first 100 HCs</p>	<p>FY 01:</p> <p>FY 00:</p> <p>FY 99: 6/00</p> <p>FY 98: 43%</p> <p><b>Norm:</b> 20%</p>	B101
2. Increase percent of users with diabetes who have had an annual dilated eye exam (New goal for FY 2001)	<p style="text-align: center;"><b>HP            BPHC</b></p> <p>FY 10: 70%    FY 01: 90%</p> <p>FY 00: 70%    FY 00: 80%</p> <p style="text-align: right;">FY 99: 70%</p>	<p>FY 01:</p> <p>FY 00:</p> <p>FY 99: 6/00</p> <p>FY 94: 57%</p> <p>FY 89: 49%</p>	<p>B101</p> <p>HP-17</p>

Performance Goals	Targets	Actual Performance	Reference
3. Increase proportion of health center women receiving age-appropriate screening for cervical and breast cancer.			B101
a) Up-to-date PAP tests	<b>HP</b> FY 10: 85% FY 00: 85%	<b>BPHC</b> FY 01: 94% FY 00: 92% FY 99: 90%	HP-16
b) Up-to-date mammograms	FY 10: 60% FY 00: 60%	FY 01: 70% FY 00: 67.5% FY 99: 65%	
c) Up-to-date clinical breast exams	FY 10: 60% FY 00: 60%	FY 01: 85.5% FY 00: 84% FY 99: 82.5%	
4. Increase proportion of Health Center adults with hypertension who report their blood pressure is under control.	<b>HP</b> FY 10: 50% FY 00: 50%	<b>BPHC</b> FY 01: 96% FY 00: 93% FY 99: 92%	B101
<b>III. ASSURE QUALITY OF CARE</b> <b>A. Appropriateness of Care</b> 1. Decrease proportion of Health Center users who are hospitalized for potentially avoidable conditions.	FY 01: 13 FY 00: 13.5 FY 99: 14	FY 01: FY 00: FY 99: 9/01 FY 98: 9/00 FY 97: 14.7/1000  <b>Norm:</b> 18.9/1000	B101
<b>Total Funding: Health Centers and the National Health Service Corps</b> (\$ in 000's)	FY 2001: \$1,182,441 FY 2000: \$1,132,507 FY 1999: \$1,037,080 FY 1998: \$ 940,064	B x: page # budget HP: Healthy People 2000 chapter	

## **2. 1. 1 Program Description, Content And Summary of Performance**

### **Context/Performance:**

Health Centers and the National Health Service Corps form a cost-effective, integrated safety net for underserved and uninsured children, adults, migrant workers, homeless individuals, public housing and U.S./Mexico border residents in approximately 4,000 communities across the country and will serve more than 11 million persons in fiscal year FY 2000 who would otherwise lack access to primary care clinicians. These 11 million persons represent about 10% of the nation's uninsured, 10% of its 33 million Medicaid recipients, and 20% of the 43 million underserved people in federally designated areas lacking access to primary care providers. This community-based network delivers preventive and primary care services for the neediest, poorest, and sickest patients in rural and inner city areas, through a Federal, State, and community partnership approach.

The high quality primary health care received in these programs reduces hospitalizations and emergency room use, reduces annual Medicaid costs, and helps prevent more expensive chronic disease and disability. Reductions in Medicaid costs range from 30 to 34%, according to a Health Center effectiveness study. Health Center Medicaid patients are 22% less likely to be inappropriately hospitalized than Medicaid beneficiaries who obtain care elsewhere. Patients at Health Centers have rates of hypertension and diabetes that far exceed national prevalence rates for comparable racial/ethnic and socioeconomic groups. Yet, Health Center diabetics are twice as likely to have their glycohemoglobin tests performed at regular intervals than national norms, and hypertensives are more than three times as likely to report that their blood pressure is under control. Health Centers have comparable rates of low birth weight deliveries as the U.S. in general despite their higher level of risk, and have reduced by 50% the persistent national gap in low-birth weight deliveries between African Americans and other racial/ethnic groups. Health Center women are far more likely to receive age-appropriate breast and cervical cancer screening, and their rates exceed the Healthy People 2010 goals. Health Center patients are far less likely to delay, postpone or not comply with treatment regimens than the Nation's poor and near poor. In fact, their level of unmet need is as low as the rate for middle and high income Americans. Having a usual and regular source of primary health care has been shown to have as much of an effect on health status disparities as income inequality. Apparently, Health Center patients are far more likely to have a usual and regular source of care than poor people of color in the Nation, which bodes well for eventual reductions and eliminations of their health status disparities.

Performance goals for the Health Centers and NHSC relate to reduction of disparities and increases in access. The conditions selected for the President's Initiative on Race provide a context for the disparity reduction goals. Health Centers and the NHSC contribute to decreases in racial and income disparities for these conditions by providing preventive services and risk reduction to a population that is largely minority (64%) and low income (86%) and disproportionately uninsured (41%). About 75% of patients are uninsured or on Medicaid which makes these sites extremely vulnerable to the market-driven downward pressure on revenues.

Specific performance indicators in this area include breast and cervical cancer screening, control of diabetic care, control of hypertension and decreases in potentially avoidable hospitalizations. Hypertension and diabetes are the most prevalent chronic conditions among Health Center users. Monitoring performance in chronic disease management for these conditions will serve as a marker for the quality of care delivered at Health Centers and sites and ultimately measure their ability to eliminate health disparities within the population served. In addition, breast and cervical cancer screening are effective measures for reducing future morbidity and mortality particularly among poor, minority, uninsured individuals. Performance here will serve as a marker for the quality of preventive care delivered and measure Health Center and site ability to reduce or eliminate disparities in early detection of disease for this population. Finally, tracking avoidable hospitalizations is a measure of access to care. Poor people of racial/ethnic minorities who are uninsured are more likely to postpone or avoid obtaining needed care which often results in more expensive hospitalizations. Avoiding these hospitalizations not only contains costs, but it indicates that such individuals consider their provider as a regular and usual source of care. Providing such care to the most vulnerable has been shown to eliminate their health disparities.

Specific performance indicators in the access area include the number of persons served by Health Centers, the field strength of the NHSC, which provides a culturally competent workforce for health centers and other sites who otherwise find it difficult to recruit clinicians on their own, and continued assurance of preventive and primary care services to low income, minority, and uninsured individuals.

Tracking individual Health Center and site performance on these measures will enable the program to continuously improve its overall level of performance. Successful strategies employed in Health Centers and sites with rates that far exceed the average can be shared with Centers and sites that could use improvement in their rates. Continuously monitoring and improving the quality of care will result in overall Program performance that moves toward the proposed targets.

### **Program-level Data Issues:**

#### **Data Issues in Determining Unmet Need for Primary Care**

BPHC has been working for several years to improve the ways in which underserved areas are identified and the unmet need for primary care is quantified. Information on these areas, known as Medically Underserved Areas/Populations (MUA/Ps) and Health Professional Shortage Areas (HPSAs) underlies the performance goals for increasing access to primary care through Health Centers and the National Health Service Corps. New regulations have been developed with input from States, affected organizations, and the academic community. The new regulations were published in the Federal Register on September 1, 1998 publication as a Notice of Proposed Rulemaking. They respond to criticism from GAO by: combining the two previously separate methods, thereby reducing burden and providing periodic updating of MUA/Ps as well as HPSAs; including J-1 visa waiver physicians and nurse practitioners, certified nurse midwives, and physician assistants in counts of primary care providers; using research-proven proxies for health status; and proactively providing validated national data to designation applicants.

BPHC has received over 800 comments on the proposed regulations. It intends to revise these regulations to take into consideration these comments, conduct new impact analyses, and then develop a new proposed rule for comment. BPHC has acquired detailed physician data and plans to acquire detailed nurse practitioner, certified nurse midwife, and physician assistant data to conduct these analyses.

### **Discussion of Data Sources**

In order to prepare for the implementation of GPRA, several years ago BPHC initiated a three-part data and evaluation strategy. First, a Uniform Data System (UDS) was developed and implemented to collect aggregate administrative, demographic, financial, and utilization data annually from each organization receiving support. This system, which combined five previously separate reporting formats, is in its fourth year of operation for 694 health center grantees and is being phased in for NHSC sites. It is validated through edit checks and onsite reviews conducted during each organization's project period. It is used to supply information for the performance goals related to access.

Second, surveys of a representative sample of health center users and provider visits were developed in collaboration with the National Center for Health Statistics. These surveys provide in-depth information on individuals and the care they receive, based on and comparable to the National Health Interview Survey (NHIS) and the National Hospital Ambulatory Medical Care Survey, (NHAMCS), respectively. The national surveys are the source of most Healthy People 2000 and 2010 objectives, which can then be used as targets for BPHC performance goals related to disparity reduction. Information from the health center User and Visit Surveys fielded in 1995 are used for baselines; BPHC plans to repeat these surveys in 2000 and at five year intervals thereafter to provide longitudinal comparisons for GPRA. In cases where BPHC performance has met or exceeded national targets, individual Program-specific targets have been established.

Third, BPHC reoriented its portfolio of other evaluation efforts, shifting from a descriptive case-study approach to the use of previously validated secondary data sources that enable a comparison of users and similar populations of non-users, and systematic sampling of organizations and users. Notable among these efforts are studies of Community Health Center Effectiveness, that use claims data from HCFA's State Medicaid Research Files (SMRF) and on-site reviews of content of care, and Hospitalizations for Ambulatory Care Sensitive Conditions, which also uses the SMRF files to examine potentially avoidable hospitalizations. As with the surveys, information from them will be used for performance goals related to disparity reduction, although some additional work is needed to develop appropriate targets and baselines. Efforts are underway to extract the information needed for follow up measures on an ongoing basis.

BPHC also plans to develop a data gathering infrastructure that will assure that performance measures are gathered annually through special studies. It will develop teams of data gathers at sentinel sites to obtain outcomes data on an annual reporting basis. Ultimately, BPHC will work to develop the data and tracking infrastructures within service delivery sites (Chronic Disease Collaborative: Diabetes, Asthma,

Hypertension) to assure prompt annual reporting on the performance measures and obtain health status outcome measures.

### **2.1.2 Goal-by-Goal Presentation of Performance**

**Goal I.A.1: Increase the number of uninsured and underserved persons served by Health Centers, with emphasis on areas with high proportions of uninsured children in order to help implement the State Child Health Insurance Program.**

**Context:**

Health Centers play an essential role in the Nation's safety net, providing preventive and primary care to nearly 20% of the 43 million underserved people in federally designated underserved areas lacking access to primary care providers.

Indicator: Total number of clients served in underserved areas.

**Performance:**

In 1998, according to data retrieved from the Bureau's Uniform Data System (UDS), 694 Health Centers served 8.67 million people in 35 million encounters at a average cost per user of about \$369 dollars. Approximately 41% of users are under the age of 19, and over 1.2 million of those children are uninsured. Grant dollars represent 26% of Health Center revenues. Medicaid revenues have dropped from 35% to 34% in 1998 while uninsured users have increased to 41%, placing additional reliance upon the Federal grant dollars. It is estimated that 9.7 million people will be served by the Centers in 2001. In addition, the number and percent of uninsured users served will continue to increase (see Goal I.C.3. below).

**Goal I. B. 1: Increase the field strength of the National Health Services Corps through scholarships and loan repayment agreements.**

**Context:**

The NHSC clinicians provide additional access to care for underserved people beyond that achieved by the Health Centers. About 60% of these clinicians are located in other practices in underserved areas.

Indicators: Total size of NHSC field strength, total unduplicated users, and total users.

**Performance:**

Currently, NHSC field strength is 2,526 serving approximately 3 million people. According to recent NHSC data, approximately 40% of NHSC clinicians serve in grant-supported sites whose users are counted above. The number of unduplicated users at NHSC non-grant-funded sites is estimated at about

2 million. The percentage of NHSC clinicians in grant-funded sites is anticipated to drop to 35% by 2001, continuing the 2.5% per year decline experienced in the last four years. There are a number of possible explanations for this decline: 1) Health Centers have become more attractive places to work, making recruitment of clinicians without obligations easier; 2) Higher NHSC retention rates result in less turnover and fewer vacancies; and 3) NHSC efforts to reach out to more unserved communities increases the total number of communities where NHSC clinicians are practicing which reduces the Health Center share while holding the number of NHSC clinicians in Health Centers at current levels.

	FY 1998 Actual	FY 1999	FY 2000 Appropriation	FY 2001
Scholarship Obligers	533	648	894	894
Federal Loan Repayers	1,306	1,282	1,323	1,323
Careerists	64	52	42	42
Obligated Feds	6	8	8	8
State Loan Repayers	508	518	414	414
Community Scholars	22	18	16	10
Total Field Strength	2,439	2,526	2,697	2,691

The NHSC will begin to collect UDS data from non-grant sites this year so that user data and other information will be available by May 2000.

**Goal I. B. 2: Increase the percent of NHSC clinicians retained in service to the underserved.**

**Context:**

Retention of NHSC clinicians preserves access to care for the underserved beyond the period of service commitment.

Indicator: Percent of NHSC clinicians who remain in service to the underserved one-year following completion of their service commitment. NHSC will provide these figures in the Annual Retention Reports.

**Performance:**

According to the NHSC 1998 Annual Retention Report, 70.4% of NHSC clinicians report remaining in service to the underserved at an interview conducted after completion of service commitment. This percentage has grown steadily from the mid 50% since 1995. Program evaluation study indicates that 60% of NHSC clinicians who completed their service commitments between 1983 and 1997 are currently in

service to the underserved. The Program plans to measure retention at one year and follow cohorts of clinicians over their working lives to assess retention at longer intervals.

**Goal I.C.1. Continue to assure access to preventive and primary care for low income individuals.**

**Context:**

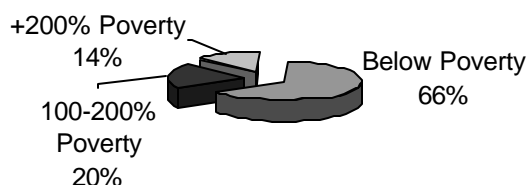
To eliminate health disparities, safety-net programs must target access to care for people of racial/ethnic minority groups, of low income, and who are uninsured.

Indicator: Proportion of Health Center and NHSC patients below 200 percent of poverty.

**Performance:**

According to UDS Health Center data, 86 percent of patient were at or below 200 percent of the Federal poverty level in FY 1998. This figure has remained constant for the three years for which UDS data have been collected.

**86% of Those Served by Health Centers Are Low Income**



With market pressures it will be a challenge for service delivery sites to remain serving such a percentage of people in poverty. It is currently estimated that the percentage of users at or below 200 percent of poverty will increase. These actuals will come from annual UDS Health Center data for 1998-2001, but by May 2000 will include UDS NHSC data.

**Goal I.C.2. Continue to assure access to preventive and primary care for minority individuals.**

**Context:**

To eliminate health disparities, safety-net programs must target access to care for people of racial/ethnic

minority groups, of low income, and who are uninsured.

Indicator: Proportion of Health Center and NHSC clientele that are underserved minorities.

**Performance:**

According to UDS Health Center data, in FY 1998 the population served included 26 percent African American, 34 percent Hispanic, and 4 percent Asian/Other.

With market pressures it will be a challenge for service delivery sites to remain serving such a minority population. It is currently estimated that the percentage of minority users will increase. These estimates will come from annual UDS Health Center data for 1998-2001, but by May 2000 will include UDS NHSC data.

**Goal I.C.3. Continue to assure access to preventive and primary care for uninsured individuals.**

**Context:**

To eliminate health disparities, safety-net programs must target access to care for people of racial/ethnic minority groups, of low income, and who are uninsured.

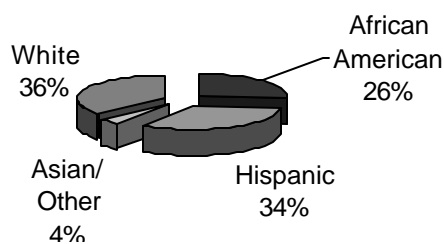
Indicator: Proportion of Health Center and NHSC clientele that are uninsured.

**Performance:**

According to UDS Health Center data, in FY 1998 the population served included more than 3.52 million uninsured, which was 41% of the client population served. More than one-third or 1.2 million of the uninsured are children. In two of five Health Centers, the majority of patients are uninsured. About 75% of Health Center patients are either uninsured or Medicaid recipients. Recent research reveals that caseloads of private physicians in the primary care specialties include 10% uninsured and 9% Medicaid for a total of 19%. Primary care clinics in hospital outpatient departments include 12% uninsured and 38% Medicaid for a total of 50%. Another more recent report noted that private physicians' charity care averaged 10 hours per month for those who did not participate in managed care and less than 5 hours for those with 85% or more revenues attributed to managed care.

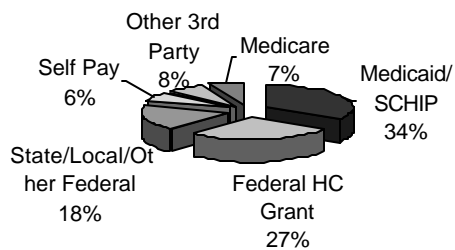
In addition, with market pressures increasing, it will be a challenge for service delivery sites to further

**Two Thirds of Those Served by Health Centers  
Are People of Color**

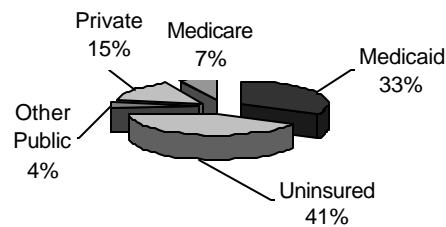


increase their role in serving such an uninsured population. Targets will be to assure that the percentage of uninsured who obtain services at BPHC sites will increase over current levels and that BPHC programs continue to serve as the safety-net providers for the Nation's uninsured, particularly those who are minorities and are at or below 200% of poverty. Uninsured Health Center users will increase by more than 200,000 between 1998 and 1999, and by an additional 300,000 each year through 2000 and 2001. The cost to Health Centers for a user to move from the roles of the insured to the uninsured is \$220 per user. Should Medicaid revenue fail to continue to cover the costs of Medicaid Health Center users as a result of the phase-in of provisions of the Balanced Budget Act of 1997, fewer grant dollars will be available to subsidize the costs of the uninsured. These estimates will come from annual UDS Health Center data for 1999-2001, but by May 2000 will include UDS NHSC data.

#### **A Quarter of Health Center Revenues Come From Federal Health Center Grants**



#### **2 Out of 5 Served by Health Centers Are Uninsured**



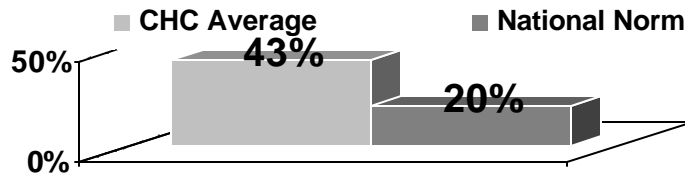
### **Goal II A. 1. Increase the proportion of users with diabetes with up-to-date testing of glycohemoglobin**

#### **Context:**

Poor people of racial/ethnic minority groups and who are uninsured are more likely to suffer from chronic diseases such as hypertension and diabetes. Health Center users have unusually high rates of these chronic diseases. Clinical evidence indicates that access to appropriate care can improve the health status of people with these chronic diseases and thus reduce or eliminate their health status disparities. Managing the glycohemoglobin levels of diabetics and the blood pressures of hypertensives can have a pronounced effect on their morbidity and mortality.

#### **Performance:**

### Health Center Diabetics Are Twice As Likely to Have Their Glycohemoglobin Tested On Schedule



According to a Health Center Effectiveness Study conducted in FY 1997, 43% of adults with diabetes had up-to-date glycohemoglobin. Based on a literature survey conducted for the Health Center Effectiveness Study, 20 percent of adults with diabetes in mainstream medical practices had their glycohemoglobin tested at ADA- recommended intervals. Despite the fact that BPHC Program users have rates that are more than twice the national average, improvement goals will be 60%, 80%, and 90%, respectively. In the first year (by June 2000), the establishment of a measurement infrastructure under the Diabetes Collaborative will enable the 100 health centers participating to reach the 90% goal. BPHC has launched a special study of medical record review to assure annual estimates of up-to-date testing and to assess health status outcome for diabetic users.

### Goal II A. 2. Increase percent of diabetic users who have had annual dilated eye exam.

Appropriate management of diabetes can have a significant effect on morbidity and mortality. Performance of regular eye exams can avoid serious limitations in functional capacity by preventing blindness in diabetics.

#### Performance:

In 1994, a Medicaid claims study of health center users revealed that 57% of adults with diabetes had a dilated eye exam within the past two years (Weiner, et al, JAMA, 1995).

Target FY 1999: 70%; 70%

Target FY 2000: 70%; 80%

Target FY 2001: 70%; 90%

Healthy People 2000 includes the following objective for adults with diabetes: Increase to 70% the proportion of people with diabetes who have an annual dilated eye exam. According to a 1989 NHIS study, 49% in the general population had such an exam. For BPHC, their program targets are 70%, 80%, and 90% respectively, anticipating results from the Diabetes Collaborative by June 2000. Also, BPHC has launched a special study of medical records to assure annual estimates of dilated eye exams and to assess health status outcomes for diabetic users.

### **Goal II. A. 3 Increase the proportion of health center women receiving age-appropriate screening for cervical and breast cancer.**

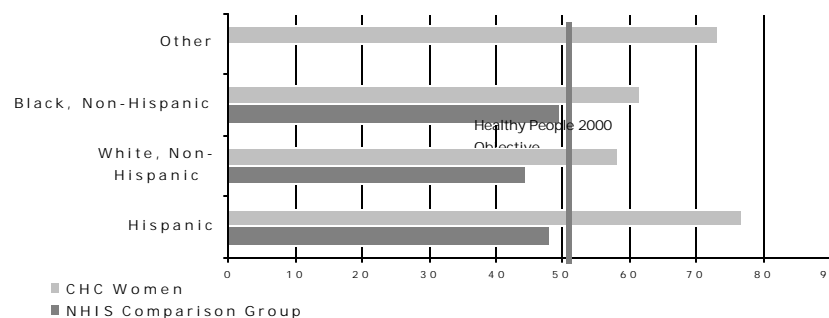
#### **Context:**

People of racial/ethnic minority groups, of low income, and who are uninsured have less access to appropriate screening and preventive services which results in their higher rates of morbidity and mortality. Access to these services can help to eliminate these health status disparities.

#### **Performance:**

The health center User Survey, comparable to the NHIS, showed the following results for health center women in 1995:

#### **Health Center Women Exceed National Comparison and Healthy People 2000 Objectives For Up-to-Date Mammograms**



Healthy People 2000 includes the following objectives for women generally, as measured by data from the National Health Interview Survey (NHIS):

1. At least 85 percent have up-to-date PAP Tests.
2. At least 60 percent have up-to-date mammograms.
3. At least 60 percent have up-to-date clinical breast examinations.

Health Center women reported being up-to-date on these examinations in higher proportions than did low-income women in the general population. Moreover, uninsured Health Center users are as up-to-date as users with insurance. In contrast to the general population, Health Centers have virtually eliminated the disparity in these indices among their users. In most cases, Health Center women met or exceeded the HP2000 objectives. Nevertheless, BPHC targets will be 90%, 92% and 94%, respectively, for up-to-date PAP tests, 65%, 67.5%, and 70% for up-to-date mammograms, and 82.5%, 84%, and 85.5% for up-to-date clinical breast exams.

Follow-up: Plans to repeat the User Survey in 2000 will provide data in April 2001. To obtain annual reporting data, BPHC will launch a special study of medical records to obtain data by May 2000. This study also will track content of care to obtain estimates of health status.

**Goal II. A. 4: Increase the proportion of Health Center adults with hypertension who report their blood pressure is under control.**

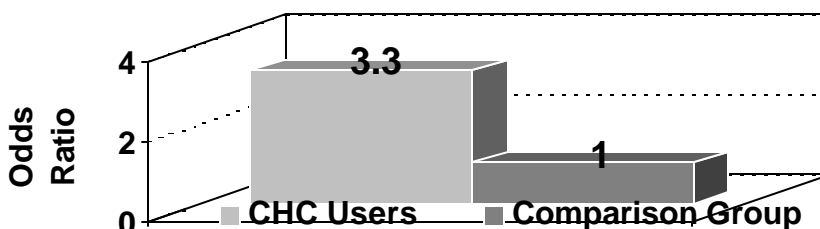
**Context:**

Hypertension is the most prevalent chronic condition facing Health Center users. Clinical evidence indicates that controlling blood pressure can reduce morbidity and mortality.

**Performance:**

The health center User Survey, comparable to the NHIS, showed the following results for health center users in 1995: 90 percent report hypertension is under control.

**African American & Hispanic Hypertensives Using Three Health Centers Are Times As Likely To Report Blood Pressure Under Control as NHIS Comparison Group**



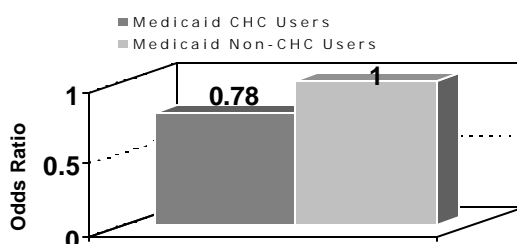
Healthy People 2000 includes the following objective for adults generally: At least 50 percent of people with hypertension report their blood pressure is under control. Despite the fact that BPHC Program users are more than three-times more likely to report blood pressure under control than a comparable national group, and that the current rate far exceeds the HP2000 objective, BPHC Program targets are 92%, 93%, and 96% respectively.

Plans to repeat the User Survey in 2000 will provide follow-up data in April 2001. BPHC has launched a special study of medical records to assure annual estimates of blood pressure control among hypertensive users and to assess health status outcomes for hypertensive users, with results by May 2000.

### **Goal III.A.1 Decrease the proportion of Health Center users who are hospitalized for potentially avoidable conditions.**

#### **Context:**

Hospitalizations for potentially avoidable conditions, otherwise known as ambulatory care sensitive conditions (ACSC) are widely recognized as a measure of access to primary care. Reducing the rate of avoidable hospitalizations for people of racial/ethnic minority groups, of low income, and who are uninsured will help eliminate their health status disparities. Low rates indicate access to appropriate ambulatory services and is a measure of high quality of care delivered. It also indicates fewer access barriers that cause patients to postpone needed services, delay needed services, and fail to comply with treatment regimens.



#### **Performance:**

An ongoing evaluation comparing ACSC hospitalizations among Health Center Users and non-users using SMRF files plus review of data from the National Hospital Discharge Survey for the general population revealed 18.9 per 1000 ACSC hospitalizations among non-

Health Center users compared to 14.7 for Health Center users. That is, Health Center Medicaid users are 22% less likely to be inappropriately hospitalized than Medicaid beneficiaries who use other providers.

#### **Medicaid CHC Users Have Significantly Lower Odds of Being Hospitalized For An Ambulatory Care Hospitalization**

To eliminate disparities, a target of 18.9/1000 would be appropriate. However, BPHC Program targets are 14, 13.5, and 13/1000, respectively, for FY 1999, 2000, and 2001 as Program should strive to eliminate virtually all avoidable hospitalizations. BPHC Program will share strategies for the reduction of avoidable hospitalizations with the Medicaid Program to help reduce such rates among other Medicaid beneficiaries. BPHC will have results from a follow-up ACSC study during 2000.

**FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report:****2.2 Program Title: Black Lung Clinics**

Performance Goals	Targets	Actual Performance	Reference
<b>I. ELIMINATE BARRIERS TO CARE</b> <b>A. Increase Utilization for Underserved Populations</b> 1. Serve Black Lung clinic users with respiratory and pulmonary impairments, including provision of medical and non-medical services.	FY 01: 35,000 users FY 00: 35,000 FY 99: 35,000	FY 01: FY 00: FY 99: 6/00 FY 98: 35,000 users	B134
<b>Total Funding: Black Lung Clinics</b> (\$ in 000's)	FY 2001:\$ 5,943 FY 2000:\$ 5,943 FY 1999:\$ 4,998 FY 1998:\$ 4,976	B x: page # budget HP: Healthy People goal	

**2.2.1 Program Description, Context and Summary of Performance****Context/Performance:**

The Black Lung program provides funding to public and private entities for the operation of clinics that provide diagnosis, treatment, and rehabilitation of active and retired coal miners with respiratory and pulmonary impairments. In addition to treatment of Black Lung disease and directly-related conditions, coverage includes prescription drugs, office visits, hospitalizations, and, with specific approval, durable medical equipment, outpatient pulmonary rehabilitation therapy, and home nursing visits. Since 1984, Black Lung beneficiaries have steadily declined. In FY 1984, approximately 100,000 primary beneficiaries filed almost 164,000 claims. Over time the number of beneficiaries will continue to decline.

**2.2.2 Goal-by-Goal Presentation of Performance**

**Goal I.A.1: Serve Black Lung clinic users with respiratory and pulmonary impairments, including provision of medical and non-medical services.**

Indicator: Number of individuals provided medical and non-medical services.

Data is collected from annual grantee reports.

Target: FY 1999:35,000 users

Target: FY 2000:35,000 users

Target: FY 2001:35,000 users

## **FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY1999 Performance Report**

### **2.3 Program Title: National Hansen's Disease Program**

<b>Performance Goals</b>	<b>Targets</b>	<b>Actual Performance</b>	<b>Reference</b>
<b>I. ELIMINATE BARRIERS TO CARE</b> <b>A. Increase Utilization for Underserved Populations</b> 1. Provide residential care for the current HD residential patients at Carville.	FY 01: 45 patients FY 00: 52 FY 99: 80	FY 01: FY 00: FY 99: 60 FY 98: 125 patients	B129
2. Provide payment of assisted living allowances for those long-term residential patients willing and able to live independently.	FY 01: 57 patients FY 00: 59 FY 99: 46	FY 01: FY 00: FY 99: 60 patients FY 98: NA	B129
3. Continue to provide outpatient care for HD patients across the country	FY 01: 3000 patients FY 00: 3000 FY 99: 3000	FY 01: FY 00: FY 99: FY 98: 3000 patients	B129
<b>Total Funding: National Hansen's Disease Program</b> (\$ in 000's)	FY 2001:\$ 19,311 FY 2000:\$ 22,337 FY 1999:\$ 23,957 FY 1998:\$ 21,886	B x: page # budget HP: Healthy People goal	

#### **2.3.1 Program Description, Context and Summary of Performance**

The Hansen's Disease program consists of the National Hansen's Disease program at Carville, Louisiana and other outpatient clinic locations in the continental United States and a direct payment to the State of Hawaii Department of Health. These activities provide or support treatment of Hansen's disease. The program also includes a research component at Louisiana State University. Funding for the renovation and modernization of buildings at the Center and the Payment to Hawaii is included in the total funding level.

HRSA is implementing legislation that relocates the National Hansen's Disease program from Carville, LA to Baton Rouge, and transfers ownership of the Carville facility to the State of Louisiana. The program has completed the move of core activities, including administration, research, clinical and skilled nursing care from the Carville facility. Some long term care functions will continue at the Carville facility.

### **2.3.2 Goal-by-Goal Presentation of Performance**

#### **Goal I.A.1. Provide residential care for the current HD residential patients at Carville.**

##### **Context:**

As part of the legislation to restructure the operation of the Hansen's Disease Center in Carville, it was agreed that continuing care would be provided for those long term residents remaining at Carville.

Indicator: Extent to which residential care continues to be provided for the remaining residents. Data for this goal is provided by program managers.

##### **Performance:**

Baseline: FY 98:125 patients

Targets:

FY 99: 80 patients - Performance: 60 patients

FY 00: 52 patients\* (Revised from 75 patients)

FY 01: 45 patients

The original estimate for FY 1999 was that 80 patients would be involved in this option. The actual performance for FY 99 was 60 patients due to a higher degree of acceptance of the option to receive an assisted living allowance and to live independently, as well as a group of 10-15 residents who require more intensive care and who have moved to Baton Rouge. Estimates for FY 2000 have also been revised from 75 to 52 patients to reflect this change in the base population.

#### **Goal I.A.2. Provide payment of assisted living allowances for those long-term residential patients willing and able to live independently.**

##### **Context:**

The legislation included in the 1998 appropriation included a provision to pay an assisted living allowance to resident patients who are capable of and elect to live independently. More patients agreed to this option than was originally estimated.

Indicator: Number of patient receiving the assisted living allowance

Data for this goal is provided by program managers.

##### **Performance:**

Targets:

FY 99: Patients receiving assisted living allowance: 60 patients

FY 00: Patients receiving assisted living allowances: 59 patients\* ( Revised from 50 patients)

FY 01: Patients receiving assisted living allowances: 57 patients

The original estimate for FY 1999 was that 46 patients would accept this option. The actual FY FY 99 performance was 60 patients due to patients receiving assisted living allowance and to live more independently. The estimates for FY 2000 and 2001 reflect this initial higher level of acceptance of stipends than originally projected.

**Goal I.A.3: Continue to provide outpatient care for HD patients across the country.**

**Context:**

The National Hansen's Disease Program includes a regional care program. The Hansen's Disease population in the U.S. approximates 6,000, of whom about 3,000 are cared for under the NHDP regional care program. Data is provided by program managers.

Indicator: Extent to which outpatient care is provided for HD patients

**Performance:**

Baseline: FY 98: 3,000 clients

Targets:

FY 99: 3,000 clients

FY 00: 3,000 clients

FY 01: 3,000 clients

## **FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report**

### **2.4 Program Title: Nursing Education Loan Repayment Program**

<b>Performance Goals</b>	<b>Targets</b>	<b>Actual Performance</b>	<b>Reference</b>
<b>I. ELIMINATE BARRIERS TO CARE</b> <b>B. Increase Access Points</b> 1. Award nursing loan repayment contracts.	FY 01: 200 contracts FY 00: 200 contracts FY 99: 200 contracts	FY 01: FY 00: FY 99: 202 contracts FY 98: 170 contracts	B135
<b>Total Funding: Nursing Loan Repayment Program</b> (\$ in 000's)	FY 2001:\$ 2,279 FY 2000:\$ 2,279 FY 1999:\$ 2,278 FY 1998:\$ 2,199	Bx: page # budget HP: Healthy People goal	

#### **2.4.1 Program Description, Context and Summary of Performance**

This program offers loan repayment to nurses in exchange for an agreement to serve not less than two years in an Indian Health Services center, in Native Hawaiian health center, in public hospital, in a health center, in rural health clinic, or in health facility determined by the Secretary to have a critical shortage of nurses. Achieving and maintaining adequate levels of nursing staff in shortage areas is the central purpose of the Nursing Education Loan Repayment Program. The program assists nurses by repaying up to 85 percent of their qualified educational loans in return for their commitment to be employed (or remain) at these health facilities.

#### **2.4.2 Goal-by-Goal Presentation of Performance**

##### **Goal I.B.1. Award nursing loan repayment contracts.**

FY 98: 170 loan repayment contracts

Targets:

FY 99: 200 loan repayment contracts - Performance: 202 contracts

FY 00: 200 loan repayment contracts

FY 01: 200 loan repayment contracts

Indicator: Number of Loan repayment contracts made

## FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report

### 2.5 Program Title: Federal Occupational Health

Performance Goals	Targets	Actual Performance	Reference
<b>I. ELIMINATE BARRIERS TO CARE</b>			Off Budget
<b>B. Increase Access Points</b> 1. Clinical Services: Provide needed basic clinical services to Federal employees.	FY 01: 227,000 served FY 00: 212,000 FY 99: 310,000	FY 01: FY 00: FY 99: 198,000 FY 98: 194,609 served	
2. Environmental Health Services: Increase the number of specific environmental services provided.	FY 01: 35,300 services FY 00: 32,600 FY 99: 27,000	FY 01: FY 00: FY 99: (2/00) FY 98: 22,281 services	Off Budget
3. Employee Assistance Program: Provide needed employee assistance services.	FY 01: 1.3M FY 00: 1.3M FY 99: 1.241M	FY 01: FY 00: FY 99: (2/00) FY 98: 1.193M	Off Budget
<b>III. ASSURE QUALITY OF CARE</b>			Off Budget
<b>C. Improve Customer/Patient Satisfaction</b> 1. Improve total customer satisfaction among Federal agencies served	FY 01: 95% satisfied FY 00: 95% satisfied FY 99: 90% satisfied	FY 01: FY 00: FY 99: (2/00) FY 98: 85% average satisfaction rate FY 97: 78% average satisfaction rate	
<b>Total Funding: Federal Occupational Health (Operating Level)</b>	FY 2001: \$90 million FY 2000: 86 million FY 1999: 83 million FY 1998: 83.146 million	B x: page # budget HP: Healthy People goal	

#### 2.5.1 Program Description, Context and Summary of Performance

##### **Context:**

The Federal Occupational Health (FOH) program provides occupational health services and consultation to federal employees. The Public Health Services Act authorizes the heads of federal agencies to provide occupational health services to their employees. Ninety-nine Departments and agencies elect to do so by

entering into agreements with the Division of Federal Occupational Health (FOH) which is a part of the Department of Health and Human Services, Health Resources and Services Administration. The FOH program provides occupational health consultation and services to other federal agencies under Economy Act inter-agency agreements. Its over-all objective is to improve the health and safety of the federal workforce. The mission statement for FOH is: To become the benchmark for occupational health in the Nation. FOH's vision is:

To be the provider of high-quality, cost-effective consultation and services that constitute a comprehensive approach, with a public health perspective, to improving the health and safety of the work force, through clinical, environmental, educational, and risk-based prevention programs.

**Program-level Performance:**

In FY 1998 FOH carried out 3,331 inter-agency agreements with 484 client federal agencies, who reimbursed FOH \$83 million. Specifically:

- C      \$39 million for basic clinical occupational health consultation and services for about 10 percent of the federal workforce, as well as for specialized clinical occupational health consultation and services. This included consultations with individual management officials and groups of managers, plus direct clinical services to individual employees and groups of employees.
- C      \$9 million for environmental health services that benefit undefined numbers of employees in worksites where environmental problem are prevented or remediated
- C      \$34 million for employee assistance programs available to over 1 million employees

The employee populations cited are not mutually exclusive. All told, FOH estimates that its programs directly benefit 1.3 million of the total 2.8 million federal employees.

**2.5.2 Goal-by-Goal Presentation of Performance**

**Goal I.B.1: Clinical Services: Provide needed clinical services to Federal employees.**

**Context:**

FOH provides clinical services to employees and consultation to management under two different types of inter-agency agreements: (1) walk-in service at permanent centers offering basic, comprehensive, nationally-standardized clinical services; and (2) specialized, on-demand-only clinical interventions wherever needed to help agency managers meet their specific occupational health responsibilities arising out of legislative and regulatory requirements or agency initiatives.

**Performance:**

In the baseline year of 1998, services were provided to approximately 195,000 employees. The FOH goal is to capture an ever-increasing share of the market for occupational health services to federal workers. There are not the usual resource restraints, since FOH is 100% reimbursable, and contract provider staff can be added as needed.

FY 99: 310,000

FY 00: 212,000\* (Revised from 352,000)

FY 01: 227,000

\*FY 00 target is based on actual FY 99 performance of 198,000 and improved data sources. The actual performance level is stated in terms of the federal population covered by FOH clinical agreements for the basic, standard package of services that is sold at a per-capita, annual rate of \$70 per eligible employee in the DC Metro area, and \$89 per elsewhere. The data is available about 6 months into the fiscal year being reported on. However, FOH also sells agencies specialized fee-for-service clinical services and consultation, which equaled (in dollar sales) the basic clinical services in FY 1997, exceeded them by \$2.5M in FY 1998, and might continue to widen the gap.

Projected levels are based on the volume of current business, a historical 95% renewal rate for clinical interagency agreements, marketing efforts, and trends such as agency budget pressures, competitors' successes, and downsizing.

**Goal I.B.2: Environmental Health Services: Increase the number of specific environmental services provided.****Context:**

Environmental health services enable customer federal agencies to comply with legislative and regulatory requirements for job safety/health and environmental matters. Methods include environmental and worker exposure monitoring, hazardous waste/materials management, safety audits, and training of employees and managers. These services meet the agency's need to create a safe workplace, and to identify, evaluate and control occupational health and environmental hazards to health. They protect employees, visitors, the general public, and the man-made and natural environment. They aid in the reduction of both work-related and non-work-related injury and illness.

**Performance:**

The baseline uses FY 1998 numbers of over 22,000 specific environmental services provided. This includes the number of safety inspections performed, indoor air quality studies done, etc. The data comes out of the FOH Management Information System. No interpretation is required. The data is available a few months after the close of the FY.

Projected levels are based on the volume of current business, marketing efforts, and trends such as agency budget pressures, competitors' successes, and downsizing.

FY 99: 27,000 services

FY 00: 32,600 services\* (Revised from 29,000)

FY 01: 35,300 services

\* Based on FY 99 data, a more current estimate for FY 00 is 32,600 services provided.

### **Goal I.B.3: Employee Assistance Program: Provide needed employee assistance programs.**

#### **Context:**

Employee Assistance Programs provide consultation to supervisors regarding employee services (assessment of employee emotional, substance abuse, or situational problems that may interfere with job performance) and short term counseling for employees. Employees are more likely to be helped early in the course of an illness when confrontation and resolution occurs in the job setting, and when the source of help is close at hand and easy to access. This reduces the cost of treatment (including Federal benefits costs) and returns the employee to a more productive status sooner, thus minimizing productivity losses. Critical incident stress debriefing benefits groups of otherwise well employees who have just suffered trauma on the job. It helps them understand normal reactions to abnormal situations, and offers individual personal assistance when necessary.

#### **Performance:**

The baseline from FY 1998 is 1.193 million employees provided employee assistance services. In terms of determining actual levels, estimates are available approximately one quarter after the end of a fiscal year.

FY 99: 1.241 million served

FY 00: 1.3 million served

FY 01: 1.3 million served

Projected levels are based on the volume of current business, marketing efforts, and trends such as agency budget pressures, competitors' successes, and downsizing.

### **Goal III.C.1: Improve total customer satisfaction among Federal agencies served.**

#### **Context/Performance:**

Customer satisfaction is measured by survey mechanisms. Fiscal year 1997 was the first year we systematically collected customer satisfaction data, so that data is the only baseline available. It showed a 78 percent satisfaction rate for federal agency occupational managers.

Data is available shortly after any given survey is done. A contractor interviews federal agency occupational health managers and other managers who are consumers of our services or consultation. The FY 1998 rating shown of 85 percent satisfaction is based on those interviews. It is somewhat expensive to have a contractor interview a large enough sample of managers to get valid numbers, so this may be done only every few years. In terms of future targets, the program reviews the last survey's numbers and estimates how much improvement can reasonably be accomplished.

Also, in 1998, we started using "how-did-we-do-today?" postcards to get satisfaction ratings from individual employees who used basic clinical services or visited an EAP counselor. Responses showed that 90 percent of users considered FOH services "excellent" and 9 percent considered them "good."

## **HIV/AIDS PROGRAMS**

### **FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report**

The programs of the HRSA HIV/AIDS Bureau provide the focal point for the Federal response to the needs of the approximately 750,000 persons estimated by CDC who are living with HIV disease and the approximately 270,000 persons living with AIDS. In 1999, an estimated 500,000 persons received HIV care and related supportive services through the HIV/AIDS Bureau programs, funded primarily with 1.4 billion dollars appropriations (fiscal year 1999) through the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 and 1996.

The HRSA HIV/AIDS care programs demonstrate a comprehensive and aggressive approach in how government has targeted dollars towards toward development of an effective service delivery system by partnering with states, heavily impacted metropolitan areas and community-based providers. Ryan White and CBC grants have placed funds where they are most needed so that hard hit communities can manage in their response to the epidemic at the local and state levels.

An estimated 4.3 million units of service were provided by Title I and II grantees in 1998. In addition, Titles III and IV reported 106,398 unduplicated clients served in FY 1998. Specific HIV health care services provided in 1998 included medical care, provision of antiretroviral treatments, dental care, mental health, substance treatment, home healthcare, rehabilitation services, and hospice care. Key health-related support service included case management, transportation, food bank, housing assistance, emergency financial assistance, among other services.

The performance report that follows provides specific updates for FY 1998 and 1999 for the diversity of programs that make up the HAB response to HIV care needs in the country. Data are presented by Section and Title or Part corresponding to the CARE Act. For example, Title I (Part A) provides for an emergency response for disproportionately affected metropolitan areas. At the same time, states funded under Title II (Part B) utilize CARE Act funds for Home- and Community-Based Care, Health Insurance Coverage, State Direct Services, and HIV Care Consortia toward the development of a broader statewide response. A separate appropriation under Part B provides critical funding specifically for HIV/AIDS therapies through the AIDS Drug Assistance Program (ADAP), bringing the benefits of effective and costly antiretroviral therapies within reach of persons with HIV unable to otherwise afford these therapies. Title III (Part C) supports community health centers, vital providers of primary care. Part C also addresses the specific population needs, such as those of reducing perinatal HIV transmission, through Title IV services and assisting families with HIV disease. Part F of the legislation addresses specific areas of need including the shortages in the health care workforce related to HIV care addressed through AIDS Education and Training Centers (AETCs), and shortages in specific health care areas such as dental health care for persons with HIV through the Dental Reimbursement Program.

While we have seen a significant decline in HIV/AIDS deaths in the last several years, there remain key

challenges facing the HAB and the CARE Act as it enters the new millennium. Of the estimated 750,000 persons living with HIV, it is estimated that over 250,000 persons are knowledgeable of their HIV status and are not in care. Most disturbing is the fact that AIDS remains a leading killer in communities of color and that the largest increases in HIV/AIDS surveillance reports are in cases among women, youth, racial/ethnic minorities, and injection drug users and their sexual partners. Geographic distribution of cases also points to the growing need to develop primary care capacity in underserved urban communities as well as in remote and underserved rural areas of the country where we see little or no HIV care infrastructure. Future efforts will focus on improvements in key areas such as data collection and management and the development of a Bureau-wide strategic plan. These efforts will contribute significantly to the Bureau's activities related to future performance measurement.

The HRSA HIV/AIDS programs are authorized by the Ryan White CARE Act, as amended, under Title XXVI of the Public Health Service Act. Programs included in this section include:

- 2.6 AIDS: HIV Emergency Relief Grants (Part A)
- 2.7 AIDS: HIV Care Grants to States (Part B)
- 2.8 AIDS: HIV Early Intervention Services (Part C)
- 2.9 AIDS: HIV Pediatric Grants
- 2.10 AIDS Education and Training Centers
- 2.11 AIDS: Dental Reimbursement Program

**FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report:**

**2.6 Program Title: AIDS: HIV Emergency Relief Grants (Part A)**

Performance Goals	Targets	Actual Performance	Reference
<b>I. ELIMINATE BARRIERS TO CARE</b> <b>B. Increase Access Points</b> 1. Increase the number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative and home health) to a level that approximates inclusion of new clients.	FY 01: 3.00M visits FY 00: 2.92M visits FY 99: 2.88M visits	FY 01: FY 00: FY 99: (1/01) FY 98: 2.79M visits FY 97: 2.77M visits FY 96 : 2.67M visits	B210
<b>II. ELIMINATE HEALTH DISPARITIES</b> <b>B. Increase Utilization for Under-served Populations</b> 1. Serve women and racial and ethnic minorities in Title I-funded programs in proportions that exceed their representation in overall AIDS prevalence by a minimum five percentage points (e.g., if 15 percent of current overall AIDS cases are among women, serve 20 percent women in Title II programs).	Women FY 01: 32% FY 00: 30% FY 99: 30%  Minorities FY 01: 66% FY 00: 64% FY 99: 64%	FY01: FY00: FY99: (1/01) FY98: Women 30.7% Minorities 67.7% FY97: Women 30.3% Minorities: 67.8% FY96: Women: 30.7% Minorities: 66.5%	B 210
<b>Total Funding: AIDS: HIV Emergency Relief Grants (Part A)</b> (\$ in 000's)	FY 2001: \$586,500 FY 2000: \$546,500 FY 1999: \$505,039 FY 1998: \$464,736	B x: page # budget HP: Healthy People goal	

**2.6.1 Program Description, Context and Summary of Performance**

The HIV Emergency Relief Grants, or Title I of the Ryan White CARE Act, provides emergency relief to eligible metropolitan areas (EMAs) that are disproportionately impacted by the HIV epidemic. These areas are eligible for Title I formula grants if they have reported more than 2,000 AIDS cases in the preceding 5 years, and if they have a population of at least 500,000 (this provision does not apply to EMAs

funded prior to FY 1997). Grants include a formula component based on estimated living cases within the EMA and a supplemental component that is competitively awarded.

The Centers for Disease Prevention and Control (CDC) has estimated that there are 750,000 persons living with HIV infection, 550,000 of whom are aware of their HIV status. Approximately 74% of the HIV infected persons who know their HIV status but are not in medical care reside in the Title I Eligible Metropolitan Areas (EMAs). CARE Act Title I funds are targeted to provide services to not only those who know their status and are in care, but to those (some 200,000) who remain unaware of their HIV status and reside in the Title I EMA.

As required through legislation, local Planning Councils assess, plan and prioritize HIV needs in their local areas based on the characteristics of populations with HIV in those areas and the realities of gaps in local service areas. This representative council composed of HIV care providers, consumers, and persons representing substance treatment, mental health, Medicaid, among other types of representatives reflecting the HIV epidemic or where care coordination is important. In 1999, EMAs continued to prioritize primary medical care, provision of antiretroviral therapies, emergency financial assistance, and case management as the high areas of need for persons with HIV disease.

In addition, FY 1998 and 1999 were the first years that HRSA/HAB implemented additional requirements related to development of health outcomes for specific funded services. HAB also strongly recommended that grantees used the “unit of service cost” concept to assure both cost effectiveness and accountability in negotiation of service contracts utilizing CARE Act funds, and required coordination between CARE Act grantees in a given area in the development of a Statewide Coordinated Statement of Need (SCSN) to foster area-wide service planning and delivery.

FY 1999 has seen additional policy development and implementation in a number of areas in order to increase cost effectiveness, access to health care and to increase guidance and technical assistance provided to grantees in using CARE Act funds. For example, in FY 1999 a policy was implemented allowing use of AIDS Drug Assistance Program (ADAP) funds for purchase of health insurance that includes the full range of HIV treatments and access to comprehensive primary care services provided that the annual amount spent on health insurance is not greater than the annual cost of maintaining that same population on the existing ADAP. Although ADAP is administered through the CARE Act Title II program (Part B), Title I grantees benefitted from having some portion of health care cost previously covered under Title I covered by health insurance, thus leaving additional funds available for the uninsured and underinsured persons with HIV in their areas.

In addition, HAB Policy 99-02, “The Use of CARE Act funds for Housing Referral Services for Short-Term or Emergency Housing Needs” was issued in 1999 to clarify the use of CARE Act funds in payment for housing related needs. This policy was developed in coordination with the US Department of Housing and Urban Development (HUD). The joint coordination between federal entities has assured a coordinated federal response in how housing needs are met. A third policy, “The Use of CARE Act funds for HIV

Diagnostics and Laboratory Tests, policy 99-03, was issued in October, 1999. This policy clarifies the use of CARE Act funds for certain diagnostic and laboratory tests and specifically allows the use of CARE Act funds for genotyping and phenotyping testing.

## **2.6.2 Goal-by-Goal Presentation of Performance**

**Goal I.B.1: Increase the number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative and home health) to a level that takes account of new clients in the program.**

### **Context:**

The measure was selected to determine access to care and use of primary care and related services. It was revised to include a more comprehensive definition of health-related care including primary medical, dental, mental health, substance abuse, rehabilitative, and home health services.

Indicator: Number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative and home health).

### **Performance:**

#### **Most Recent Actual Performance**

FY 1998: 2.79 million visits

In FY 1998, 2.79 million visits were reported by 51 Title I Eligible Metropolitan Area (EMA) grantees, including 2,600 providers of funded and eligible services. Providing the core response by metropolitan areas hardest hit by the AIDS epidemic, these grantees provided health care and related supportive services to hundreds of thousands of persons living with HIV/AIDS.

#### **Target Performance**

FY 1999: 2.88 million visits

FY 2000: 2.92 million visits\*

FY 2001: 3.00 million visits\*

\* Performance measure targets for FY 2000 and FY 2001 were revised based on estimated 2.86 visits by Title I providers in FY 1999. This estimate and the adjusted targets are based on best professional judgement, taking into account the revision of the measure to include HAB's complete definition of medical care (i.e., primary medical, dental, mental health, substance abuse, rehabilitative and home health).

**II.B.1: Serve women and racial and ethnic minorities in Title I funded programs in proportions that exceed their representation in overall AIDS prevalence by a minimum five percentage points (e.g., if 15 percent of current overall AIDS cases are among women, serve 20 percent women in Title I programs).**

### **Context:**

This measure addresses HRSA's overall strategy to eliminate disparity in access to care and to increase

services to populations that have been traditionally under served. Benefits provided by new combination drugs (anti-retrovirals/protease inhibitors) have not uniformly reduced the incidence of AIDS between genders or racial and ethnic minorities. Despite the reduction seen in overall AIDS morbidity, annual incidence data show the proportion of AIDS cases among women and minorities continue to increase.

HRSA CARE Act programs have prioritized increasing access to these new drugs among these vulnerable populations. In addition, new program guidance, Title III planning grant specifications, and AIDS Education Training Center training activities are examples of Agency efforts in reducing service utilization disparities in communities of color.

Indicator: Proportion of women and racial and ethnic minorities served in Title I funded programs compared to proportion of women and racial and ethnic minorities of the total population who are living with AIDS.

**Performance:**

<u>Most Recent Actual Performance</u>	FY 1998	30.7% women 67.7% minorities
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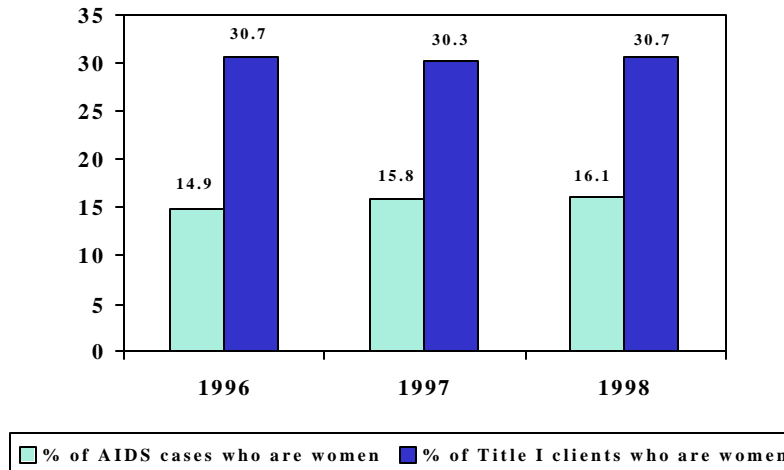
In FY 1998, the percent of AIDS patients seen by Title I providers increased by 0.4%, an increase which is consistent with the increase in the estimated percent of all AIDS cases for the year (0.5%).

As shown in CHARTS II.B.1-A and II.B.1-B, the Title I-funded programs are successfully meeting and, in the case of serving racial and ethnic minorities, exceeding their target performance measures. It should also be noted that the performance targets for FY 99, 2000 and 2001 are all significantly higher than the target specified in the indicator itself (i.e., five percent higher than the representation of women and racial/ethnic minorities among all AIDS cases in the Nation).

<u>Target Performance</u>	FY 1999	30% women 64% minorities
	FY 2000	30% women 64% minorities
	FY 2001	32% women 66% minorities

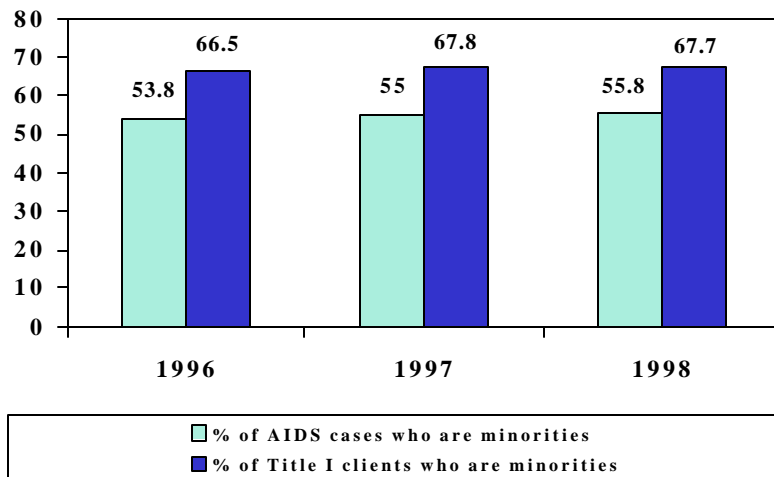
**CHART II.B.1-A**<sup>1,2</sup>

**Percent of women served by Title I grantees  
compared to % of AIDS cases who are women in U.S.**



**CHART II.B.1-B**<sup>1,2</sup>

**Percent of women served by Title I grantees  
compared to % of AIDS cases who are minorities in U.S.**



<sup>1</sup> Data source for percent of women and minorities among all U.S. AIDS cases is Centers for Disease Control and Prevention end-of-year *HIV/AIDS Surveillance Report* for 1996-1998.

<sup>2</sup> Data for Title I funded programs represents duplicated clients.

### Developmental Performance Outcome Measure

A developmental performance indicator that measures three key clinical measures is under consideration for Titles I and II. The three clinical measures are: 1) percentage of women receiving pap smears; 2) percent of clients who receive PCP prophylaxis treatment; and 3) percent of clients who receive a TB skin test.

Currently, there are no data available on these measures to serve as a baseline and/or to develop appropriate targets. During the upcoming year (FY 2000), data will be received from the 7-8 sites collecting client level data; these data will also be included on the Annual Administrative Reports (AAR) for all Title I and II grantees, although grantees will provide it on a voluntary basis. Once the data from these sources are available, a final decision regarding the development of this performance measure will be made. Given the importance of including outcome as well as output measures in the Bureau's performance plan, every effort will be made to develop these measures further and to include them in the FY 2002 annual plan.

### **Data Issues:**

#### **Data Source(s) for Performance Goals**

Data for performance goals A and B are obtained from the following sources:

- C Annual Administrative Reports
- C Grant Applications
- C Grantees' Needs Assessments

#### **Data Limitations and Planned Improvements**

Data provided by Title I grantees on the Annual Administrative Reports (AAR) contain duplicated client/beneficiary counts. HRSA/HAB continues efforts to investigate methods to measure the unduplicated number of beneficiaries/clients receiving medical and social support services from Ryan White Programs. Recently, HRSA/HAB contracted with Harvard University, School of Medicine to develop mathematical models for unduplicating client numbers using the AAR data. Their preliminary findings, based on clients who received one or more services in calendar year 1996, have been successful in demonstrating possible methods to determine an unduplicated count. Additionally, a small number of Part A and Part B grantees have been attempting to demonstrate methods to collect and report client-level data. These efforts are projected to lead to a way to readjust, as necessary, the numbers of beneficiaries and the level of services use per client, given that former estimates have been based on duplicated client data.

#### **FY 1999 Data**

FY 1999 data for Title I grantees will be available January 2001.

**FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report**

**2.7 Program Title: AIDS: HIV Care Grants to States (Part B)**

<b>Performance Goals</b>	<b>Targets</b>	<b>Actual Performance</b>	<b>Reference</b>
<b>I. ELIMINATE BARRIERS TO CARE</b> <b>B. Increase Access Points</b> 1. Increase the number of visits for health-related care (primary, medical, dental, mental health, substance abuse, rehabilitative and home health) to a level that takes account of new clients in the program.	FY 01: 1.57M visits FY 00: 1.53M visits FY 99: 1.22M visits	FY 01: FY 00: FY 99: (1/01) FY 98: 1.45M visits FY 97: 1.07M visits	B212
<b>II. ELIMINATE HEALTH DISPARITIES</b> <b>B. Increase Utilization for Underserved Populations</b> 1. Increase the number of ADAP clients receiving appropriate anti-retroviral therapy (consistent with clinical guidelines) through State ADAPs during at least one month of the year.	FY 01: 74,800 clients* FY 00: 71,900 clients* FY 99: 78,088 clients * FY 2000 and 2001 targets revised based on actual performance of 64,500 for FY 99.	FY 01: FY 00: FY 99: 64,500 clients FY 98: 55,000 clients FY 97: Data not available. Data system initiated in Feb. 1998	B212
2. Serve women and racial and ethnic minorities in Title II funded programs in proportions that exceed their representation in overall AIDS prevalence by a minimum five percentage points (e.g., if 15 percent of current overall AIDS cases are among women, serve 20 percent women in Title II programs).	Women FY 01: 28% FY 00: 27% FY 99: 27%  Minorities FY 01: 60% FY 00: 59% FY 99: 59%	FY01: FY00: FY99: (1/01) FY98: Women: 29.4% Minorities: 64.1% FY97: Women 30.3% Minorities: 63.1% FY96: Women: 26.3% Minorities: 59.9%	B212
<b>Total Funding: AIDS: HIV Care Grants to States (Part B)</b> (\$ in 000's)	FY 2001: \$864,000 FY 2000: \$824,000 FY 1999: \$737,765 FY 1998: \$542,784	B x: page # budget HP: Healthy People goal	

### **2.7.1 Program Description, Context and Summary of Performance**

#### **Context:**

Title II HIV CARE Act grants to States (Part B) provide formula grants to 50 States, the District of Columbia, Puerto Rico, the Virgin Islands and Guam to provide health care and support services for people living with HIV disease. The amount of the grant to the state is based on the estimated living cases of AIDS within the state in the most recent 10 calendar years and the estimated living cases of AIDS within the state but outside of any EMAs within the state in the most recent 10 calendar years. States with more than 1 percent of the total AIDS cases reported nationally during the previous 2 years must contribute their own resources to match the Federal grant.

#### **Program-wide Performance:**

In FY 1999, Title II funds continued to be used to support a wide range of health care and related supportive services including:

- C Home and community-based health care and support services;
- C Continuation of health insurance coverage, through a Health Insurance Continuation Program (HICP);
- C Pharmaceutical treatments, through the ADAP Program;
- C HIV care consortia that assess needs, organize and deliver HIV services in consultation with service providers, and contract for services;
- State direct services.

In 1998 and 1999, HRSA/HAB implemented additional requirements related to development of health outcomes, definition of unit of service cost, and coordination between CARE Act grantees in a given area in the development of a Statewide Coordinated Statement of Need (SCSN) reported under the Title I report above. The Title II programs were legislatively responsible for the coordinated development of the Statewide Coordinated Statement of Need (SCSN) and this responsibility, posed a significant challenge for states in bringing together grantees under Titles I, II, III, IV, AIDS Education and Treatment Centers (Part F) and Dental Reimbursement Programs (Part F) to jointly assess and plan for the needs in the grantee state. All 54 states and territories filed a SCSN statement which was updated and reported on in FY 1998.

FY 1999 also saw additional Title II policy development and implementation in a number of areas in order to increase cost effectiveness, access to health care and to increase guidance and technical assistance provided to grantees in using of CARE Act funds. These policies included housing related expenses and laboratory and diagnostic testing.

#### **AIDS Drug Assistance Program (ADAP)**

Starting in 1996, specific AIDS Drug Assistance Program (ADAP) funds were made available to states in their Title II awards in response to the rapid growth in ADAP clients and costs, and to expand access to newly available anti-retroviral therapies. Additionally, ADAPs are using earmark funds to

purchase health insurance that includes the full range of HIV treatments and access to comprehensive primary care services as another cost effective means of providing therapies to eligible clients.

In FY 1999, the ADAP program's ability to provide medications to underserved populations has improved significantly for the most part. Specifically:

The number of State ADAPs with waiting lists, decreased from nine in 1997 to five in 1999.  
The total number of clients on waiting lists has decreased from 3,478 in 1998 to 1,581 in 1999.

The percentage of ADAPs with 26 or more drugs on their formulary increased from 49 percent in 1997 to 68 percent in 1999.

ADAPs that set financial eligibility above 200 percent FPL has increased from 56 percent in 1997 to more than 65 percent in 1999.

In 1999, 83 percent of all ADAPs require only an HIV positive diagnosis for eligibility, versus 1997-1998, where 24-25 percent of State ADAPs set additional medical eligibility criteria (CD4 counts, Western Blot, etc.).

From 1997 to 1999, the number of State ADAPs participating in the Section 340B Drug Discount Program has increased from 19 to 45 (a 137 percent increase). Savings from cost-recovery strategies increased from \$25.9 million in 1997 to \$54.5 million in 1999.

In January, 1999, HAB policy 99-01 was released pursuant to FY 1999 appropriations language that supporting the use of AIDS Drug Assistance Program (ADAP) funds for the purchase of health insurance that includes the full range of HIV treatments and access to comprehensive primary care services. The policy indicates that the annual amount spent on health insurance must not be greater than the annual cost of maintaining that same population on the existing ADAP. It is estimated that 15 grantees are currently taking advantage of the new provisions by purchasing health insurance products for clients.

### **2.7.2 Goal-by-Goal Presentation of Performance**

**Goal I.B.1: Increase the number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative and home health) to a level that takes account of new clients in the program.**

#### **Context:**

This performance goal was selected to determine access to care and use of primary care and related services. However, with the move toward integrated Health Care Systems at the State level, it is more difficult to track specific client visits. Instead, the Program is moving to look broadly at outcomes at both the clinical and systems level.

Indicator: Number of visits for health-related care (primary medical, dental, substance abuse, mental

health, home health and rehabilitative).

**Performance:**

<u>Most Recent Actual Performance</u>	FY 1998	1.45 million visits
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In FY 1998, Title II programs provided an estimated 380,000 additional visits, representing a 26.2% increase over FY 1997. The actual performance for this measure in FY 98 exceeded the FY 99 target by approximately 230,000 visits. A revised estimate of FY 99 performance of 1.49 million visits for health-related care provided by Title II programs was calculated.

<u>Target Performance</u>	FY 1999: 1.22 million visits
	FY 2000: 1.53 million visits*
	FY 2001: 1.57 million visits*

\* FY 2000 and FY 2001 targets were revised based on an estimated 1.49 million visits to Title II programs in FY 1999. Both the revised FY 99 estimate and the revised FY 2000 and 2001 targets take into account the HAB's complete definition of medical care including primary medical, dental, mental health, substance abuse, rehabilitative and home health care).

**Goal II.B.1: Increase the number of ADAP clients receiving appropriate anti-retroviral therapy (consistent with clinical guidelines) through State ADAPs during at least one month of the year.**

**Context:**

This goal was originally selected to be a good performance measure given the changes in the epidemic and the advent of highly effective anti-retroviral therapy (HAART) to treat the disease. As it is currently written, however, the measurement of this goal is beyond the data management and administrative capacity of current ADAP grantees. A significant portion of ADAP clients may receive medications from other sources, including Medicaid, other Ryan White CARE Act local pharmacy assistance programs, private insurance, or through clinical trials. Additionally, it is not uncommon for ADAP clients to switch between systems in a single reporting period. The available data, therefore, could give an incomplete drug therapy history, and therefore distort the results of whether clients are receiving "appropriate" anti-retroviral therapy consistent with the PHS treatment guidelines (i.e., "current clinical guidelines"). In addition, HRSA does not have the statutory authority to require ADAPs to compare their utilization data to the PHS treatment guidelines to determine if clients are receiving "appropriate" anti-retroviral therapy ("consistent with clinical guidelines)." HRSA does, however, maintain an ADAP formulary database in order to monitor national formulary trends. HRSA also works continually with ADAPs on formulary development in order to ensure that, to every extent possible, the appropriate drugs are included on each of the State's formulary.

A potential revision to this goal is under consideration; this revised goal would include the number of people enrolled in ADAP programs and receiving medications on a monthly basis and would delete the

words “appropriate” and “consistent with current clinical guidelines”.

Indicator: Number of individuals receiving appropriate anti-retroviral therapy (consistent with current clinical guidelines) through State ADAPs during at least one month of the year.

**Performance:**

Most Recent Actual Performance

FY 99: 64,500 clients

In FY 1999, an average of 64,500 persons were served each month by ADAP. In comparison with monthly figures from FY 1998, an average of 9,500 additional clients were receiving anti-retroviral therapies through ADAP per month in FY 1999. The original FY 99 target of 78,088 average clients per month served by ADAP was not met due to a revision in the program’s data collection system. The ADAP Monthly Report (AMR) on which this measure is based, was implemented in February 1998. By FY 1999, the system had been successfully implemented with a resulting improvement in the accuracy of the reported number of clients receiving services through ADAP each month. This improvement in the data will allow a more accurate determination of appropriate targets for this measure in the future.

Target Performance for Future Years

FY 00: 71,900 clients

FY 01: 74,800 clients

The revised FY 2000 and FY 2001 targets are revised based on actual performance in FY 99 of 64,500 average clients served per month, as well as FY 2000 appropriations and the FY 2001 President’s budget request.

**Goal II.B.2: Serve women and racial and ethnic minorities in Title II funded programs in proportions that exceed their representation in overall AIDS prevalence by a minimum five percentage points (e.g., if 15 percent of current overall AIDS cases are among women, serve 20 percent women in Title II programs).**

**Context:**

This goal directly relates to HRSA overall strategy to eliminate disparity in access to care and to increase services to populations that have been traditionally underserved.

Benefits provided by new combination drugs (anti-retrovirals/protease inhibitors) have not uniformly reduced the incidence of AIDS between genders or racial and ethnic minorities. Despite the reduction seen in overall AIDS morbidity, annual incidence data show the proportion of AIDS cases among women and minorities continue to increase.

HRSA CARE Act programs have prioritized increasing access to these new drugs among these vulnerable populations. In addition, new program guidance, Title III planning grant specifications, and AIDS Education Training Center targeted training activities are an example of Agency targeted efforts

in reducing service utilization disparities in communities of color.

Indicator: Proportion of women and racial and ethnic minorities served in Title II funded programs compared to proportion of women and racial and ethnic minorities of the total population who are living with AIDS.

**Performance:**

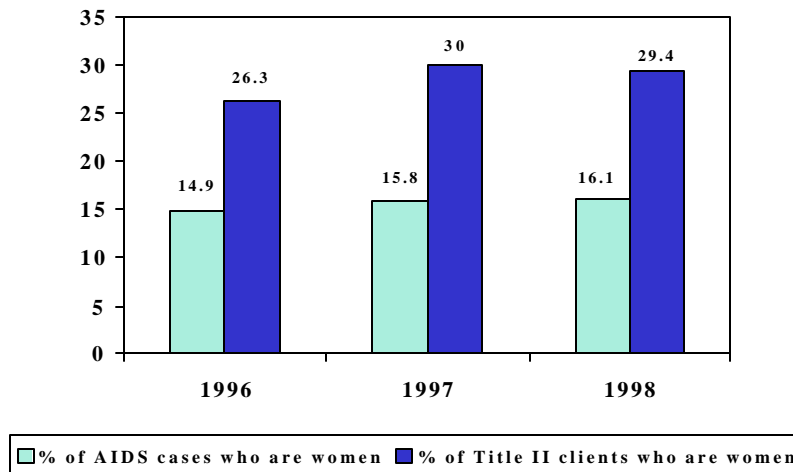
<u>Most Recent Actual Performance</u>	FY 1998	29.4% women 64.1% minorities
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As shown in CHARTS II.B.2-A and II.B.2-B, the Title II-funded programs are successfully meeting their target performance measures. It should also be noted that the performance targets for FY 99, 2000 and 2001 are all significantly higher than the target specified in the indicator itself (i.e., five percent higher than the representation of women and racial/ethnic minorities among all AIDS cases in the Nation).

<u>Target Performance</u>	FY 1999	27% women 59% minorities
	FY 2000	27% women 59% minorities
	FY 2001	28% women 60% minorities

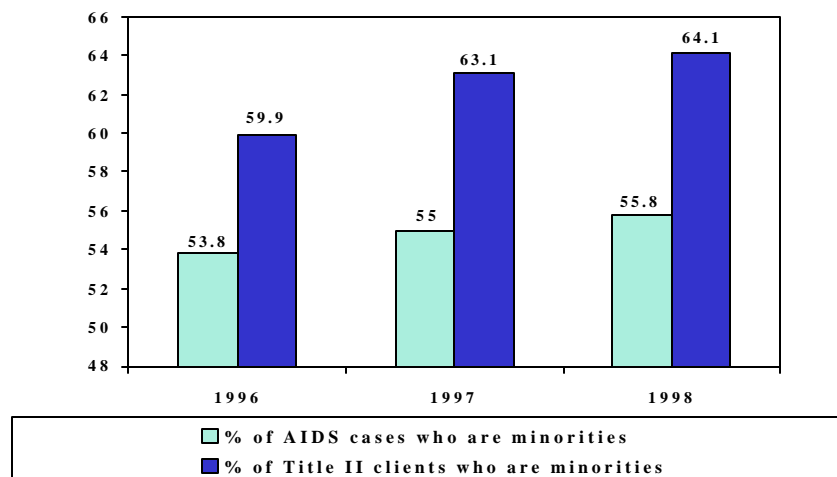
**CHART II.B.2-A<sup>1,2</sup>**

**Percent of women served by Title II grantees  
compared to % of AIDS cases who are women in U.S.**



**CHART II.B.2-B<sup>1,2</sup>**

**Percent of minorities served by Title II grantees  
compared to % of AIDS cases who are minorities in U.S.**



<sup>1</sup> Data source for percent of women and minorities among all U.S. AIDS cases is Centers for Disease Control and Prevention end-of-year *HIV/AIDS Surveillance Report* for 1996-1998.

<sup>2</sup> Data for Title II funded programs represent duplicate clients.

### Developmental Performance Outcome Measure

A developmental performance indicator that measures three key clinical measures is under consideration for Titles I and II. The three clinical measures are: 1) percentage of women receiving pap smears; 2) percent of clients who receive PCP prophylaxis treatment; and 3) percent of clients who receive a TB skin test.

Currently, there are no data available on these measures to serve as a baseline and/or to develop appropriate targets. During the upcoming year (FY 2000), data will be received from the 7-8 sites collecting client level data; these data will also be included on the Annual Administrative Reports (AAR) for all Title I and II grantees, although grantees will provide it on a voluntary basis. Once the data from these sources are available, a final decision regarding the development of this performance measure will be made. Given the importance of including outcome as well as output measures in the Bureau's performance plan, every effort will be made to develop these measures further and to include them in the FY 2002 annual plan.

### **Data Issues:**

#### **Data Source(s) for Performance Goals**

Data for performance goals A and B are obtained from the following sources:

- C Annual Administrative Reports
- C Grant Applications
- C Grantees' Needs Assessments

### **Data Limitations and Planned Improvements**

Data provided by Title II grantees on the Annual Administrative Reports (AAR) contain duplicated client/beneficiary counts. HRSA/HAB continues efforts to investigate methods to measure the unduplicated number of beneficiaries/clients receiving medical and social support services from Ryan White Programs. Recently, HRSA/HAB contracted with Harvard University, School of Medicine to develop mathematical models for unduplicating client numbers using the AAR data. Their preliminary findings, based on clients who received one or more services in calendar year 1996, have been successful in demonstrating possible methods to determine an unduplicated count. Additionally, a small number of Part A and Part B grantees have been attempting to demonstrate methods to collect and report client-level data. These efforts are projected to lead to a way to readjust, as necessary, the numbers of beneficiaries and the level of services use per client, given that former estimates have been based on duplicated client data.

### **FY 1999 Data**

FY 1999 data for Title II grantees should be available January 2001.

**FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report**

**2.8 Program Title AIDS: HIV Early Intervention Services (Part C)**

<b>Performance Goals</b>	<b>Targets</b>	<b>Actual Performance</b>	<b>Reference</b>
<b>I. ELIMINATE BARRIERS TO CARE</b> <b>A. Increase Utilization for Underserved Populations</b> 1. Increase the number of people receiving primary care services under Early Intervention Services programs.	FY 01: 120,398 clients FY 00: 110,398 clients FY 99: 90,433 clients	FY 01: FY 00: FY 99: (1/01) FY 98: 105,398 clients FY 97: 96,451 clients	B215
<b>II. ELIMINATE HEALTH DISPARITIES</b> <b>B. Increase Utilization for Underserved Populations</b> 1. Increase the number of racial and ethnic minorities who are receiving primary care services under Early Intervention Programs.	FY 01: 84,179 (70%) FY 00: 77,279 (70%) FY 99: 60,000 (66%)	FY 01: FY 00: FY 99: (1/01) FY 98: 72,242 (69.7%) FY 97: 63,423 (65.8%) FY 96: 54,573 (64.5%)	B215
<b>Total Funding: (Program Title)</b> (\$ in 000's)	FY 2001:\$171,400 FY 2000:\$138,400 FY 1999:\$ 94,270 FY 1998:\$ 76,211	B x: page # budget HP: Healthy People goal	

**2.8.1 Program Description, Context and Summary of Performance**

**Context:**

Title III of the Ryan White CARE Act authorizes a program to support outpatient HIV early intervention services for people in existing primary care systems, and supports comprehensive primary health care and other services for individuals who have been diagnosed with HIV disease. The program specifically targets previously underserved populations, which have had limited access to care, including women, children, adolescents, racial and ethnic minorities, and substance abusers.

**Program-wide Performance:**

The 208 Title III currently funded programs represent a cross-section of community-based and public

organizations. They include: 1) Federally-funded community health centers, 2) non-federally funded community-based health centers; and city and county health departments, 3) hospital or university-based medical centers, 4) other types of organizations including - health care for the homeless centers, family planning clinics, and comprehensive hemophilia diagnostic and treatment centers. These programs provide a range of services including:

- Risk-reduction counseling, partner involvement in risk education, education to prevent transmission, antibody testing, medical evaluation, and clinical care;
- Anti-retroviral therapies; protection against opportunistic infections, and ongoing medical, oral health, nutritional, psychosocial, and other care for HIV infected clients;
- Case management to assure access to services, and continuity of care for HIV-infected clients;
- Addressing “co-epidemics” that occur frequently in association with HIV infection, including tuberculosis and substance abuse.

In FY 1999, fund became available through Title III planning grants to bolster HIV/AIDS care to African Americans and individuals in rural and underserved areas. Over 10 application guidance technical assistance meetings were held in FY 1999 to announce availability of Ryan White funds especially to grantees serving new, targeted underserved communities.

A total of 79 planning grants were awarded by the Title III program to public and private organizations in FY 1999. These planning grants are designed to help communities that lack adequate HIV care resources improve their ability to deliver primary care to individuals with HIV. The grants are used specifically to help organizations that primarily serve African Americans affected by HIV/AIDS strengthen their planning and administrative activities.

## **2.8.2 Goal-by-Goal Presentation of Performance**

### **Goal I.A.1: Increase the number of people receiving primary care services under Early Intervention Services Programs.**

Indicator: The number of people receiving primary care services under Early Intervention Services Programs.

#### **Performance:**

<u>Most Recent Actual Performance</u>	FY 1998	105,398 clients
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In FY 1998, Title III Early Intervention Program continued to exceed its FY 1999 target of 90,433 clients receiving primary care services. A total of 105,398 persons received these services in FY 1998, an increase of 9.3% in new clients served compared to FY 1997. Risk exposure information shows the largest percentage increase of persons served with HIV disease who are heterosexual and injection drug users in comparison with client data from FY 1997.

Target Performance

FY 1999: 90,433 clients

FY 2000: 110,398 clients\*

FY 2001: 120,398 clients\*

\*The target performance for FY 2000 and FY 2001 was revised based on the Early Intervention Program's successful performance (i.e, in excess of its FY 1999 target). An updated estimate of clients receiving primary care services through the Early Intervention Program was used in the development of these revised targets.

**Goal II.B.1: Increase the number of racial and ethnic minorities who are receiving primary care services in Early Intervention Programs.**

**Context:**

This goal directly relates to HRSA overall strategy to eliminate disparity in access to care and to increase services to populations that have been traditionally underserved.

Indicator: The number of racial and ethnic minorities receiving primary care services in Ryan White Title III Early Intervention Programs.

**Performance:**

Most Recent Actual Performance

FY 1998: 72,242 (69.7%)

In FY 1998, the Title III Early Intervention Program provided services to approximately 72,000 racial and ethnic minorities, an increase of 14% (8,819 minority clients), compared to FY 1997. The Program's performance over the past two years has exceeded the original FY 1999 target of 60,000 racial and ethnic minorities receiving primary care services. The level of performance reflects significantly increased efforts across all of the Ryan White CARE Act programs to target communities of color. Despite the reduction seen in overall AIDS morbidity, annual incidence data show the proportion of AIDS cases among women and minorities continue to increase. In addition, benefits provided by new combination drugs (anti-retrovirals/protease inhibitors) have not uniformly reduced the incidence of AIDS among racial and ethnic minorities.

Target Performance

FY 1999: 60,000 (66%)

FY 2000: 77,279 (70%)\*

FY 2001: 84,179 (70%)\*

\*The target performance for FY 2000 and FY 2001 was revised based on the Early Intervention Program's successful performance (i.e, in excess of its FY 1999 target). An updated estimate of racial and ethnic minority clients receiving primary care services through the Early Intervention Program in FY 99 was used in the development of these revised targets.

**Data Source(s) for Performance Goals**

Data for performance goals I.A.1 and II.B.1 are obtained from the annual Title III Early Intervention Program Data Reports

FY 1999 data for Title III grantees will be available in January, 2001.

**FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report****2.9 Program Title: AIDS: HIV Pediatric Grants (Women, Children, Youth)**

Performance Goals	Targets	Actual Performance	Reference
<b>I. ELIMINATE BARRIERS TO CARE</b> <b>A. Increase Utilization for Underserved Populations</b> 1. Increase the number of enrolled female clients provided comprehensive services, including appropriate services before or during pregnancy, to reduce perinatal transmission.	FY 01: 15,000 enrolled females FY 00: 14,470 enrolled females FY 99: 13,900 enrolled females	FY 01: FY 00: FY 99: (1/01) FY 98: 11,000 enrolled females FY 97: 9,469 enrolled females	B218
<b>III. ASSURE QUALITY OF CARE</b> <b>B. Assure Effectiveness of Care</b> 1. Decrease by 5 percent annually the number of newly reported AIDS cases in children as a result of perinatal transmission	FY 01: 193* FY 00: 203* FY 99: 214* * Target measures for this indicator were revised based on revised data used to measure actual performance.	FY 01: FY 00: FY 99: (1/01) FY 98: 225* FY 97: 310* FY 96: 502* * Data used to measure actual performance were revised.	B218
<b>Total Funding: HIV Pediatric Grants (Women, Children and Youth)</b> \$ in 000's	FY 2001: \$60,000 FY 2000: \$51,000 FY 1999: \$45,985 FY 1998: \$40,803	B x: page # budget HP: Healthy People goal	

### **2.9.1 Program Description, Context and Summary of Performance**

Title IV of the Ryan White CARE Act develops and supports programs that provide coordinated, comprehensive, family-centered systems of care and enhanced access to clinical and other research activities for children, youth, women and families infected with and affected by HIV/AIDS. The Title IV client populations require intensive case management, child and respite care, and unique models of direct service delivery. In addition to providing community-based medical and social support services these systems of care must be directly linked to the National Institute of Health and other clinical research trials. Innovative models funded under this program must organize, arrange for, and deliver comprehensive services to these populations maximizing and utilizing all existing ongoing systems of care. Title IV programs serve the unique and varying needs of their specific service areas by utilizing extensive and culturally competent outreach to provide access to a seamless system of care for all client populations.

Project areas funded under Title IV include:

- Grants for Coordination of HIV Services and Access to Research for Children, Youth, Women and Families;
- African American Children's Initiative;
- Adolescent Initiative Grants;
- Continuous Quality Improvement Initiative (to be implemented in FY 2001).

### **2.9.2 Goal-by-Goal Presentation of Performance**

**Goal I.A.1: Increase the number of enrolled female clients provided comprehensive services, including appropriate services before or during pregnancy, to reduce perinatal transmission.**

Indicator: The number of female clients enrolled in Title IV programs receiving comprehensive services, including appropriate services before to during pregnancy to reduce perinatal transmission.

#### **Performance:**

##### **Most Recent Actual Performance**

FY 1998

11,000 enrolled females

In FY 1998, the Title IV program continued to see an increase in numbers of enrolled women receiving comprehensive services, including appropriate services before, during or after pregnancy to reduce perinatal transmission. In FY 1998, there was an estimated 16% increase over FY 1997 figures in the number of women enrolled in the program.

##### **Target Performance for Future Years**

FY 99: 13,900 enrolled females

FY 00: 14,470\* enrolled females

FY 01: 15,000\* enrolled females

**Goal III.B.1: Decrease by 5 percent annually the number of newly reported AIDS cases in children as a result of perinatal transmission.**

Indicator: Number of reported AIDS cases in children as a result of perinatal transmission according to CDC Surveillance data reports.

### Performance:

<u>Most Recent Actual Performance</u>	FY 1998	225 cases*
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\*HAB, in collaboration with the Centers for Disease Control and Prevention (CDC) and the Assistant Secretary for Management and Budget, has selected an alternate data source for measuring performance related to the reduction of perinatal HIV transmission. The new data source is based on an estimate of pediatric AIDS cases by year of diagnosis; the previous source was based on pediatric AIDS cases by the year reports were received by CDC.

It is important to note that, regardless of the data source used, pediatric AIDS cases as a result of perinatal transmission continues to decrease. Based on the revised data source, estimated pediatric AIDS cases by year of diagnosis, there was a 27.4% decline in mother to child HIV perinatal transmission between FY 1997 and FY 1998.

Decreasing the annual number of newly reported AIDS cases demonstrates the effectiveness of the Title IV program's perinatal HIV transmission reduction activities. These activities include 1) improving access for HIV positive pregnant women to new therapies that have high success rates in preventing the transmission of HIV to newborns; 2) facilitating participation in clinical trials that provide these women access to state-of-the-art treatments; and 3) successfully identifying increasing numbers of HIV positive pregnant women before or early in their pregnancy and providing effective counseling regarding medications to decrease risk of perinatal transmission.

Target Performance for Future Years    FY 1999: 214 cases\*

FY 2000: 203 cases\*

FY 2001: 193 cases\*

\*Revised performance targets were developed for this indicator by applying the five percent annual decrease in newly reported pediatric AIDS cases from the original goal to the actual FY 1998 performance of 225 cases based on the updated data source for measuring this indicator.

## Data Issues:

Source(s): Title IV Data Report and CDC *HIV/AIDS Surveillance Reports*

FY 1999 data for Title IV programs will be available January, 2001.

## FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report

### 2.10 Program Title: AIDS Education and Training Centers

Performance Goals	Targets	Actual Performance	Reference
<b>IV. IMPROVE PUBLIC HEALTH AND HEALTH CARE SYSTEMS</b> <b>B. Promote Education and Training of the Public Health and Health Care Workforce</b> 1. Increase the number of minority health care and social service providers who receive training in AETCs.	FY 01: 127,000 providers FY 00: 117,000 providers FY 99: 107,582 providers	FY 01: FY 00: FY 99: (1/01) FY 98: 89,549 providers FY 97: 88,817 providers	B221
<b>Total Funding: AIDS Education and Training Centers</b> \$ in 000's	FY 2001: \$29,150 FY 2000: \$26,650 FY 1999: \$19,994 FY 1998: \$17,216	B x: page # budget HP: Healthy People goal	

#### 2.10.1 Program Description, Context and Summary of Performance

##### **Context:**

The National AIDS Education and Training Centers (AETC) Program is a network of 14 regional centers (with more than 75 local performance sites) that conduct targeted, multi disciplinary HIV education and training programs for health care providers. The mission of these centers is to increase the number of health care providers who are effectively educated and motivated to counsel, diagnose, treat and manage individuals with HIV infection and to assist in the prevention of high risk behaviors which may lead to infection. AETC represents the Bureau's efforts to build the pool of available HIV care trained professionals.

##### **Program-wide Performance:**

During FY 1998 and FY 1999 AETC program focused on further refinement of its efforts in several areas. For example, ongoing clinical consultation was added as an integral part of the Centers' responsibility to assure that providers would receive ongoing assistance in using educational training in their clinical work. This activity was supplemented by the HRSA/AETC National HIV Telephone Consultation Service which provides general support to HIV care providers nationwide. In addition, the AETC programs incorporated more "hand-on" experience and revised their training format to

incorporate an interactive workshop environment instead of using primarily a lecture format.

In FY 1999, several national AETC Centers were established, the AETC Resource Center, the AETC Evaluation Centers, and the National Minority AETC. The AETC Resource Center was established to increase sharing of information and decrease duplication in training activities among the currently funded AETCs. The AETC Evaluation Centers were established to improve documentation of educational outcomes of the AETC programs. The National Minority AETC was charged with increasing the pool of trained minority health care professionals.

### **2.10.2 Goal-by-Goal Presentation of Performance**

**Goal IV.B.1: Increase the number of minority health care and social service providers who receive training in AETCs.**

Indicator: Number of minority health care providers who receive training in AETCs.

#### **Performance:**

Most Recent Actual Performance                      FY 1998:        89,549

In FY 1998 a total of 89,549 minority health care providers were trained through AETC programs. Given the increasing proportion of AIDS cases among racial and ethnic minorities -- more than 60 percent of clients currently receiving care and services under the CARE Act are minorities -- improving the clinical education and training for minority providers is critical in managing the increasing number of cases among communities of color.

#### **Data Issues:**

##### **Data Source for Performance Goal**

AETC Evaluation Data System

#### **FY 1999 Data**

FY 1999 data for the AIDS Education and Training Centers will be available in January, 2001

## FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report

### 2.11 Program Title: AIDS: Dental Services Program

Performance Goals	Targets	Actual Performance	Reference
<b>III. ASSURE QUALITY OF CARE</b> <b>A. Promote Appropriateness of Care</b> 1. Increase the number of persons for whom a portion of their unreimbursed oral health costs were reimbursed.	FY 01: 46,200 persons FY 00: 46,000 persons FY 99: 66,000 persons	FY 01: FY 00: FY 99: 46,000 persons	B223
<b>Total Funding: AIDS: Dental Services Program</b> \$ in 000's	FY 2001: \$8,500 FY 2000: \$8,000 FY 1999: \$7,798 FY 1998: \$7,762	B x: page # budget HP: Healthy People goal	

#### 2.11.1 Program Description, Context and Summary of Performance

##### **Context:**

The Dental Services Program is designed to partially reimburse accredited dental schools and other graduate dental education programs for the documented uncompensated costs they have incurred for providing oral health treatment to HIV infected patients for twelve-month periods which are specified annually.

##### **Performance:**

In 1999, the HRSA HIV/AIDS [Ryan White CARE Act] Dental Reimbursement Program provided an average award of 49 percent of unreimbursed costs to 93 institutions in support of dental care for approximately 46,000 HIV positive patients.

#### 2.11.2 Goal-by-Goal Presentation of Performance

##### **Goal III.A.1: Increase the number of persons for whom a portion of their unreimbursed oral health costs were reimbursed.**

Indicator: The number of persons for whom a portion of unreimbursed oral health costs were reimbursed.

**Performance:****Most Recent Actual Performance**

FY 1999: 46,000 persons

A new reporting system for the Dental Services Program has recently been approved by the Office of Management and Budget. This system, which was initiated during the last reporting period, will be fully operational in FY 2000. It provides a more accurate count of the number of beneficiaries within the Dental Services Program; the previous measurement only provided an estimate. The number of clients seen in FY 1999 is based on the new reporting system

**Target Performance for Future Years**

FY 2000: 46,000 clients\*

FY 2001: 46,200 clients\*

\*Performance targets for FY 2000 and FY 2001 were revised based on the Actual FY 1999 performance of 46,000 persons for whom a portion of unreimbursed oral health costs were reimbursed by the Dental Services Program. The revised performance targets also included consideration of the increasing costs of oral health care.

**Data Issues:**

Data Source for Performance Goal is the Dental Service Program Grant Applications

# **MATERNAL AND CHILD HEALTH**

## **FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report**

The Maternal and Child Health Bureau (MCHB) provides leadership, partnership and resources to advance the health of all of our Nation's mothers, infants, children, and adolescents-including families with low income levels, those with diverse racial and ethnic heritage and those living in rural or isolated areas without access to care.

The Bureau draws upon nearly a century of commitment and experience. Early efforts are rooted in MCHB's predecessor, the Children's Bureau, established in 1912. Major program efforts of the Bureau include:

- 2.12 Maternal and Child Health Block Grant - Title V
  - 2.12.a Healthy Start Initiative
  - 2.12.b Traumatic Brain Injury Program
- 2.13 Universal Newborn Hearing Screening and Early Intervention
- 2.14 Emergency Medical Services for Children
- 2.15 Poison Control Centers
- 2.16 Abstinence Education Program

**FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report**

**2.12 Program Title: Maternal and Child Health Block Grant - Title V**

<b>Performance Goals</b>	<b>Targets</b>	<b>Actual Performance</b>	<b>Refer- -ence</b>
<b>I. ELIMINATE BARRIERS TO CARE</b> <b>A. Increase Utilization for Underserved Populations</b> 1. Decrease the percent of children without health insurance.	FY 01: 10%	FY 01: FY 00: FY 99: (Jan, 01) FY 98: (Apr, 00) FY 97: 14% FY 96: FY 95: 14%	B195
2. Increase the percent of potentially Medicaid eligible children who have received a service paid by the Medicaid program.	FY 01: 80%	FY 01: FY 00: FY 99: (Jan, 01) FY 98: (Apr, 00) FY 97: 70%	B195
3. Increase the number of children served by Title V.	FY 01: 24M	FY 01: FY 00: FY 99: (Jan, 01) FY 98: (Apr, 00) FY 97: 20.2 million	B195
4. Increase the percent of children with special health care needs (CSHCN) in the State with a medical/health home.	FY 01: 80%	FY 01: FY 00: FY 99: (Jan, 01) FY 98: (Apr, 00) FY 97: 69%	B195
5. Increase the percent of CSHCN in the State program with a source of insurance for primary and specialty care.	FY 01: 90%	FY 01: FY 00: FY 99: (Jan, 01) FY 98: (Apr, 00) FY 97: 83%	B195

6. Increase the percent of infants born to pregnant women receiving care beginning in the first trimester.	FY 01: 90 %	FY 01: FY 00: FY 99: (April, 01) FY 98: FY 97: 82.5 %	B195  HP-14
<b>II. ELIMINATE HEALTH DISPARITIES</b> <b>A. Reduce Incidence/Prevalence of Disease and Morbidity/Mortality</b> 1. Decrease the ratio of the black infant mortality rate to the white infant mortality rate.	FY 01: 2.1 to 1	FY 01: FY 00: FY 99: (Sept, 01) FY 98: FY 97: FY 96: 2.4 to 1 FY 95: 2.3 to 1	B195  HP-14
<b>III. ASSURE QUALITY OF CARE</b> <b>B. Assure Effectiveness of Care</b> 1. Decrease the infant mortality rate	FY 01: 6.9/1000 FY 00: 7.0/1000	FY 01: FY 00: FY 99: (April, 01) FY 98: (Apr, 00) FY 97: 7.1/1000 FY 96: 7.3/1000 FY 95: 7.6/1000	B195  HP-14
<b>Total Funding: Maternal and Child Health Block Grant</b> (\$ in 000's)	FY 2001: \$799,130 FY 2000: \$799,130 FY 1999: \$804,744 FY 1998: \$776,605 (Funding totals include Healthy Start and Traumatic Brain Injury)	B x: page # budget HP: Healthy People goal	

### 2.12.1 Program Description, Context and Summary of Performance

The MCH Block Grant is the only Federal program that focuses solely on improving the health of mothers and children. It is specifically intended to (1) reduce infant mortality, (2) provide and ensure access to comprehensive prenatal and postnatal care to women, (3) increase the number of children

receiving health assessments and follow-up diagnostic and treatment services, (4) provide and ensure access to preventive and child care services, (5) provide and promote family-centered, community-based, coordinated care for children with special health care needs (CSHCN), and (6) identify pregnant women and infants who are eligible for Title XIX (Medicaid) and to assist them in applying for services, through outreach and enrollment.

The program has three main components: formula grants to States; and two Federally- administered discretionary project grant programs, special projects of regional and national significance (SPRANS); and community integrated service systems (CISS). These components are administered in a complementary fashion in support of providing quality health care to all mothers and children.

The MCH Block Grant is a public health program that complements the Medicaid and SCHIP health insurance programs which pay for a defined set of medically necessary services for low-income individuals meeting specific eligibility requirements. Historically, State Medicaid programs have relied on State MCH programs not only for maintaining the medical infrastructure, but also for assistance in enrolling eligible women and children, developing policies, procedures and practice standards that help providers and other agencies work more effectively with Medicaid, and organizing and providing services not available or accessible in the private sector.

In 1997 the Maternal and Child Health Bureau initiated a new Performance Partnership with the States. As part of this effort, MCHB and the States conducted a 16 month process in which representatives of the States, concerned interest groups, experts in public health, maternal and child health, public health data, and State data systems all participated. The process included two major meetings with representatives of all the State maternal and child health Directors, and extensive discussions with and input from the States. The purpose was to completely re-design the Block Grant Annual Report and Application Guidance, both in structure and process, to include a set of core performance measures that all States would report on, and a set of State-specific measures that individual States would negotiate with MCHB. The Annual Report and Application were re-structured around the core and State specific performance measures. The MCHB GPRA measures for the MCH State Block Grant program aggregate and use the State core measures to assess the overall performance of the whole State Block Grant program.

### **2.12.2 Goal-by-Goal Presentation of Performance**

An initial set of MCHB GPRA measures has been identified to measure the national impact of the MCH State Block Grant program. These measures are based on the core set of measures that the States started reporting on, under the new Performance Partnership with the States, in FY 1998. The MCHB GPRA measures for the MCH State Block Grant program either aggregate and use the State-reported core measures data or, for vital statistics measures, the most recent CDC data to assess the overall performance of the State Block Grant program.

**Goal I.A.1: Decrease the percent of children without health insurance.**

**Context:**

While the association between insurance status and utilization of health care services is well documented in adults, less is known about the utilization of services by children. A 1996 study by Harvard, The Kaiser Foundation and National Opinion Research Center found the uninsured were four times more likely to have an episode of needing but not getting medical care. Other data indicate that children without health insurance have an average of one fewer visits per year, and receive less care than insured children with similar problems.

**Performance:**

Baseline: 14% of children without health insurance (1995).

Performance FY 97: 14%

Target FY 01: 10%

Indicator: The Percent of children without health insurance.

It is clear that HRSA is only one piece in helping to achieve this goal and that this is a nationwide problem that can only be solved with Federal, State and Community participation. MCHB will review the performance data reported by the States when it is edited, assembled and available this Spring. After sharing that data with HCFA and ASMB, HRSA will consider whether to revise the FY 01 Target.

**Goal I.A.2: Increase the percent of potentially Medicaid eligible children who have received a service paid by the Medicaid program.**

**Context:**

Financial access to health care does not guarantee that all children will enroll and access care, but insured children are more likely to get care. Currently 4 million children are estimated to be eligible non-participants in Medicaid. By encouraging and helping all Medicaid-qualified children to enroll, State Title V programs help ensure access to health care services.

**Performance:**

Baseline FY 97: 70%

Performance FY 97: 70%

Target FY 01: 80%

Indicator: The percent of potentially Medicaid eligible children who have received a service paid by the Medicaid program.

**Goal I.A.3: Increase the number of children served by Title V.**

**Context:**

The primary objective of Title V of the Social Security Act is “to improve the health of all mothers and children,” especially under-served populations. Increasing the number of children served by Title V is central to accomplishing this purpose.

**Performance:**

Baseline: 20.2 million

Performance FY 97: 20.2 million

Target FY 01: 24 million

Indicator: The number of children served by Title V.

**Goal I.A.4: Increase the percent of children with special health care needs (CSHCN) in the State with a medical/health home.****Context:**

The MCHB accepts the American Academy of Pediatrics definition of and recommendation regarding the necessity of a medical/health home, and considers such a source of care to be essential for children with special health care needs.

**Performance:**

Baseline: 69% in FY 1997.

Performance FY 97: 69%

Target FY 01: 80%

Indicator: The percent of children with special health care needs (CSHCN) in the State with a medical/health home.

**Goal I.A.5: Increase the percent of CSHCN in the State program with a source of insurance for primary and specialty care.****Context:**

CSHCN are disproportionately low income, and because of this, they are at higher risk for being uninsured. Moreover, because their needs for health services extend beyond those required by healthy children, they are more likely to incur catastrophic expenses. Since children are more likely to obtain health care if they are insured, this measure is an important indicator of access to care.

**Performance:**

Baseline: 83% in FY 1997.

Performance FY 97: 83%

Target FY 01: 90%

Indicator: The percent of CSHCN in the State program with a source of insurance for primary and specialty care.

**Goal I.A.6: Increase the percent of infants born to pregnant women receiving care \ beginning in the first trimester.**

**Context:**

Early identification of maternal disease and risks for complications of pregnancy or birth are the primary reason for first trimester entry into prenatal care. This can help assure that women with complex problems and women with chronic illness or other risks are seen by specialists. Early high-quality prenatal care is critical to improving pregnancy outcomes. CDC data are used for this performance measure.

**Performance:**

Baseline: 81% began prenatal care in first trimester (1995).

Performance FY 97: 82.5%

Target FY 01: 90%

Indicator: The percent of infants born to pregnant women receiving care beginning in the first trimester.

**Goal II.A.1: Decrease the ratio of the black infant mortality rate to the white infant mortality rate.**

**Context:**

While the U.S. has made significant progress in reducing the overall infant mortality rate, there is still significant disparity in the rate for selected racial groups. The disparity for Black infant mortality is more than twice the White rate. CDC data are used for this performance measure.

**Performance:**

Baseline (1995): Black rate: 14.0 deaths per 1000 live births; White rate: 6.0 deaths per 1000.

Ratio: 2.3 to 1

Performance FY 96: 2.4 to 1

Performance FY 97:

Target FY 01: 2.1 to 1

Indicator: The ratio of the black infant mortality rate to the white infant mortality rate.

**Goal III.B.1: Decrease the infant mortality rate**

**Context:**

All countries of the world measure the infant mortality rate as an indicator of general health status. The U.S. has made progress in reducing this rate, but the rate of decline has slowed in the last 10 years. CDC data are used for this performance measure.

**Performance:**

Baseline: 7.6 deaths per 1000 live births (1995).

Performance FY 97: 7.1/1000

Target FY 01: 6.9/1000

Indicator: The infant mortality rate.

**Data Issues:**

Data for the measures specified above are tabulated from the State Block Grant annual report and application, except for vital statistics data, which come from CDC.

The Maternal and Child Health Block Grant program, after extensive consultations with States and OMB, instituted performance-based reporting from all States, accompanied by electronic reporting, in FY 1998. The Maternal and Child Health Bureau had worked closely with the States to complete a re-engineering of the Maternal and Child Health (MCH) Block Grant Annual Report and Application Guidance into a single process. The revised approach includes not only a standardization of the application and reporting procedures required by the authorizing legislation (Title V of the Social Security Act), but also incorporates reporting on a set of quantitative performance measures.

The new guidance provides for an application/annual report process that is uniform for all States and jurisdictions, captures all the data required in the Title V legislation, and incorporates the principles of Performance Partnerships. Concurrent with the redesign of the Guidance, an electronic reporting system was developed that allows the States to submit their applications/annual reports electronically. It capture all of the qualitative programmatic information as well as the quantitative data necessary for performance measurement. In FY 1999, MCHB is implementing the Title V Information System, which provides users access to the consolidated data reported by all 50 States and 9 jurisdictions.

**Data Limitations and Planned Improvements:**

Significant improvements in the quality of data have already been accomplished by the standardization of definitions and formats imposed both in the new Performance Partnership and by the new electronic reporting format. One feature of the electronic reporting format requires that the raw data for rates and ratios be entered, and all calculations are done by the program. One difficulty facing MCHB is that different States have different data capabilities. This leads to the result that some kinds of data are collected by some States on a periodic basis - every two or three years, for example - while other kinds of data may vary in currency across States - so that not all States report data from the same year at the same time. MCHB will provide intensive additional assistance to the States in achieving standard data capabilities.

**FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report**

**2.12.a Program Title: Healthy Start Initiative**

<b>Performance Goals</b>	<b>Targets</b>	<b>Actual Performance</b>	<b>Reference</b>
<b>I. ELIMINATE BARRIERS TO CARE</b> <b>A. Increase Utilization for Underserved Populations</b> 1. Reduce the percentage of enrolled women who receive late or no prenatal care. (New)	FY 01: 16.75%	FY 01: FY 00: FY 99: (Sept, 00) FY 98: 17.06%	B198
<b>III. ASSURE QUALITY OF CARE</b> <b>B. Assure Effectiveness of Care</b> 1. Decrease the percentage of low birth weight babies born to Healthy Start clients. (Revised) Original wording: Decrease by 1% the number of low and very low birth weight babies born to Healthy Start clients.	FY 01: 11.75%	FY 01: FY 00: FY 99: (Sept, 00) FY 98: 12.09% (Provisional)	B198
<b>Total Funding: Healthy Start (\$ in 000's)</b>	[FY 2001: \$90,000] [FY 2000: \$90,000] [FY 1999: \$104,967] [FY 1998: \$95,526] (Funding for Healthy Start is included in the MCH Block Grant line.)	B x: page # budget HP: Healthy People goal	

**2.12.a.1 Program Description, Context and Summary of Performance**

**Context:**

The FY 2001 Budget proposes that funds be made available first to continue making grants to Healthy Start grantees that were awarded funds on or before January 15, 2000, whose current grant award

continues in FY 2001. If the total amount of such grant awards is less than \$90 million, at least 95 percent of the remaining funds will be available for States, under the cost sharing provisions of section 503 of the Social Security Act, according to the ratio that infant mortality in each State bears to the total of infant mortality in the U.S. Up to five percent of remaining funds are to be available for States for technical assistance. This would help to ensure a greater level of commitment toward collaboration and cooperation by State and local perinatal health systems in support of communities. The program will continue to target communities with racial, ethnic, and geographical disparity in perinatal health and other significant problems that contribute to high infant mortality. The grantees will be expected to implement strategies that complement their State maternal and child health systems and enhance collaboration with and among States in carrying out essential activities, such as Medicaid and the State Children's Health Insurance Program (SCHIP).

Healthy Start focuses on the need to strengthen and enhance community systems of perinatal health. It does this by helping communities to fully address the medical, behavioral and psychosocial needs of women and infants. The FY 2001 program will provide for a continuing opportunity to reduce factors contributing to infant mortality by adaptation of successful Healthy Start models of intervention in urban and rural communities with high rates of infant mortality, especially among racial/ethnic populations, and to share the lessons learned with States, communities, and academic and professional organizations.

#### **Program-wide Performance:**

In FY 1997, the Healthy Start program concluded its demonstration phase (Phase I). Twenty-two of the high risk communities, together with public/private partnerships implemented strategies to address the broad range of health, social, economic and educational unmet needs that result in high rates of infant mortality. A review of final reports from the projects which document their experience reveals their success in building community-based coalitions and achieving community-wide service system integration, improved care coordination, expanded level and range of services, and alleviation of other barriers to care. Cost savings have resulted from reducing low birth weight through promotion of healthy behaviors such as prenatal care visit compliance, smoking cessation and substance abuse treatment. In addition, the Healthy Start program is having broader impact on on-going public and private sector partnerships that have facilitated welfare to work and community job creation.

In the replication phase (Phase II), which began in FY 1998, actions were initiated to carry out three specific program goals: 1) expand the success of the Healthy Start program by replicating models of perinatal care which have shown evidence of strengthening the perinatal system: to date, 41 new communities are replicating infant mortality reduction strategies in their communities; 2) establish a peer mentoring program: to date, 20 projects from the demonstration phase are serving as peer mentors to new Healthy Start communities and other health care providers while continuing efforts to improve the perinatal health for women, infants and their families in their own communities; and 3) nationally disseminate knowledge and information on lessons learned: the Healthy Start National Resource Center project is fully operational and serves this purpose.

## **2.12.a.2 Goal-by-Goal Presentation of Performance**

**Goal I.A.1: Reduce the percentage of enrolled women who receive late or no prenatal care.**

**Context:**

This is a new goal added to better reflect the expected outcomes for the Healthy Start population.

Indicator: The percentage of enrolled women who receive late or no prenatal care.

**Goal III.B.1 Decrease the percentage of low birth weight babies born to Healthy Start clients.** (This goal has been re-stated to make it more specific, and to adjust its format.)

**Original wording: Decrease by 1% the number of low and very low birth weight babies born to Healthy Start clients.**

Indicator: Number of deliveries/births weighing 1500-2499 grams.

**Performance:**

Provisional data reported by grantees indicates a baseline of 12.09% for the client populations served in CY 1998. Not all grantees have their own source for these data. Where it is necessary to use vital statistics data, reporting will take longer.

The following developmental performance goals have been set-aside in favor of goals more related to expected outcomes for the Healthy Start population:

**Increase by 25% the utilization of comprehensive community-driven health services in project areas by pregnant/parenting women and infants.**

**Increase community and provider understanding of the SCHIP and its eligibility requirement, provider location, service reimbursement and relevant issues. SCHIP outreach, enrollment, consumer advocacy and quality monitoring functions at all Healthy Start sites.**

**Ensure 90% of the infants of Healthy Start clients receive age appropriate immunizations.**

**Data Issues:**

Data for the performance goals will come from the Healthy Start Replication Phase Data Reporting Requirements, developed in collaboration with the Healthy Start grantees to be useful for both Federal and grantee purposes. The requirements were pilot-tested and are being submitted for OMB clearance.

**Data Limitations and Planned Improvements:**

As noted earlier, community-based grantees do not always start with the capacity to provide all the data that might be desired. The Healthy Start program has worked with grantees to help them develop data systems appropriate to their functions and objectives, and have advised them on alternative sources and strategies for data. This assistance and advice will continue.

**FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report**

**2.12.b Traumatic Brain Injury Program**

<b>Performance Goals</b>	<b>Targets</b>	<b>Actual Performance</b>	<b>Reference</b>
<b>IV. IMPROVE PUBLIC HEALTH AND HEALTH CARE SYSTEMS</b> <b>B. Promote Education and Training of the Public Health and Health Care Workforce</b> 1. Increase the number of States with educational and training materials, and programs for consumers, families and professionals.	FY 01: 15 FY 00: 11 FY 99: 7	FY 01: FY 00: FY 99: 8 FY 98: 0 (7 in process)	B198
<b>C. Promote Systems and Infrastructure Development</b> 1. Increase the number of States with TBI core capacity that includes: a State Action Plan, Statewide Needs Assessment, designated State agency staff, and State Advisory Board.	FY 01: 35 FY 00: 30 FY 99: 25	FY 01: FY 00: FY 99: 25 FY 98: 13	B198
<b>Total Funding: Traumatic Brain Injury Program</b> (\$ in 000's)	[FY 2001: \$5,000] [FY 2000: \$5,000] [FY 1999: \$4,998] [FY 1998: \$2,991] (Funding for the TBI program is shown in the Maternal and Child Health Block Grant line).	B x: page # budget HP: Healthy People goal	

**2.12.b.1 Program Description, Context and Summary of Performance**

Congress has authorized HRSA to improve services for traumatic brain injury (TBI) survivors through a program of demonstration grants to States to improve health and other services for the assessment and treatment of TBI. The TBI Demonstration Grant Program is designed to emphasize activities by States that implement State-wide systems that ensure access to comprehensive and coordinated TBI

services. A comprehensive system of care is needed to improve all aspects of services available for individuals with TBI and their families including: pre-hospital care, emergency department care, hospital care, rehabilitation, transitional services, education and employment, and long-term community support.

According to a recent General Accounting Office (GAO) study of services, adults with TBI often have permanent disability that requires long-term supportive services to remain in the community. In an analysis of nine States, the gap between the number of individuals with TBI receiving long-term services and the estimated number of disabled adults with TBI remains wide.

The HRSA TBI program is part of a three HHS agency effort with CDC and NIH. Collaboration occurs with the Department of Education/Office of Special Education and Rehabilitation services, the Veteran's Administration, and the Administration on Developmental Disabilities.

#### **2.12.b.2 Goal-by-Goal Presentation of Performance**

##### **Goal IV.B.1: Increase the number of States with educational and training materials, and programs for consumers, families and professionals.**

###### **Context:**

Increasing the number of States with educational and training materials, and programs for consumers, families and professionals will increase the knowledge base and improve care delivery for TBI patients.

Indicator: Number of States with educational and training materials and programs.

Performance: FY 99 Actual Performance was higher than the FY 99 Target.

##### **Goal IV.C.1: Increase the number of States with TBI core capacity that includes: a State Action Plan, Statewide Needs Assessment, designated State agency staff, and State Advisory Board.**

###### **Context:**

The identified components of TBI core capacity are critical to assuring increased quality of care for TBI patients.

Indicators:

- Number of States with a State Action Plan (Baseline 13).
- Number of States with a Statewide Needs Assessment (Baseline 13).
- Number of States with a designated State agency staff (Baseline 13).
- Number of States with a State Advisory Board (Baseline 25).

**Performance:**

FY 99 Actual Performance met the FY 99 Target.

The following two goals have been discontinued. The difficulty in measuring them exceeds their value as indicators.

**Goal IV.C.2: Increase the number of States that coordinate public (RSA, Special Education, Medicaid, Title V, etc.) and private (insurance, etc.) resources to assist individuals and families in developing long-term financial support to secure community and/or health services.**

**Goal IV.C.3: Increase the number of States that track program implementation of services for people with TBI to narrow the gap between those disabled by TBI who receive services and those disabled by TBI not receiving services.**

**Data Issues:**

Data to be collected from an annual survey of grantees, being developed and prepared for OMB clearance.

**FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report**

**2.13 Program Title: Universal Newborn Hearing Screening**

<b>Performance Goals</b>	<b>Targets</b>	<b>Actual Performance</b>	<b>Reference</b>
<b>III. ASSURE QUALITY OF CARE</b> <b>A. Promote Appropriateness of Care</b> 1. Increase the percentage of newborns who have been screened for hearing impairment before hospital discharge. (New)	FY 01: 40%	FY 01: FY 00: FY 99: (June, 00) FY 98: 20%	B203
<b>Total Funding: Universal Newborn Hearing Screening</b> (\$ in 000's)	FY 2001: \$3,375 FY 2000: \$3,375 FY 1999: n/a FY 1998: n/a	B x: page # budget HP: Healthy People chapter	

**2.13.1 Program Description, Context and Summary of Performance**

HRSA proposed a new program for FY 2000 to promote newborn hearing screening as a standard of care. This initiative will address critical gaps by supporting grants to the States to: (1) develop and expand statewide universal newborn hearing screening programs, (2) link screening programs to intervention within the community service system, (3) monitor the impact of early detection and intervention on child, family, and systems, and (4) provide technical assistance.

At the current stage of development of the universal newborn hearing program in this country, 80 percent of infants are still not screened prior to hospital discharge. In those areas where universal newborn hearing screening is occurring, appropriate and timely diagnosis and intervention continues to be a major challenge. Attrition rates as high as 60 percent between initial referral and diagnostic confirmation are still not unusual, and linkages between screening programs and early intervention programs are yet not well-established.

This effort is one component of an on-going multiple agency partnership with the CDC, NIH, and the Department of Education.

### **2.13.2 Goal-by-Goal Presentation of Performance**

**Goal III.A.1: Increase the percentage of newborns who have been screened for hearing impairment before hospital discharge.** (New Performance Goal)

**Context:**

This Goal replaces the four developmental goals (see below) proposed last year, as a measure more accurately reflecting the activities proposed and the health outcomes being addressed, and one for which data are available.

Increasing the percentage of newborns who have been screened for hearing impairment before hospital discharge is the first step toward improving the early diagnosis and treatment of infants with hearing impairment.

Indicator: The percentage of newborns who have been screened for hearing impairment before hospital discharge.

The following four developmental goals have been replaced:

- \* 90 percent of eligible infants will be referred to and receive early intervention services by 6 months of age. (Developmental)
- \* 90 percent of infants identified through screening programs will have an identified medical home. (Developmental)
- \* The average age of diagnosis will be reduced to 3 months, with amplification by 6 months. (Developmental)
- \* 50 states will have established statewide universal newborn hearing screening programs. (Developmental)

**Data Issues:**

**Data Collection and Validation:**

Data for the new performance goal is available from the National Center for Hearing Assessment and Management (NCHAM). It is also reported annually by the States in the Title V State Block Grant Annual Report and Application, as Performance Measure #10.

**Data Limitations and Planned Improvements:**

The data obtained from NCHAM are at least as good as the data reported by the States annually.

**FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report**

**2.14 Emergency Medical Services for Children**

<b>Performance Goals</b>	<b>Targets</b>	<b>Actual Performance</b>	<b>Reference</b>
<b>IV. IMPROVE PUBLIC HEALTH AND HEALTH CARE SYSTEMS</b> <b>C. Promote Systems and Infrastructure Development</b> 1. Increase the number of States that have implemented Statewide pediatric protocols for medical direction. (Modified wording to focus on Statewide implementation.)	FY 01: 15 (Statewide) FY 00: 20 (Statewide/partial) FY 99: 18 (Statewide/partial)	FY 01: FY 00: FY 99: 25 (10 Statewide, 15 partial) FY 98: 16 ( 6 Statewide, 16 partial)	B205
2. Increase the number of States that require all EMSC-recommended pediatric equipment on Advanced Life Support (ALS) ambulances.	FY 01: 23 FY 00: 10 FY 99: 7	FY 01: FY 00: FY 99: 18 FY 98: 5	B205
<b>Total Funding: Emergency Medical Services for Children</b> (\$ in 000's)	FY 2001: \$15,000 FY 2000: \$17,000 FY 1999: \$14,995 FY 1998: \$12,941	B x: page # budget HP: Healthy People goal	

**2.14.1 Program Description, Context and Summary of Performance**

The EMSC program is designed to ensure that all children and adolescents, no matter where they live or where they travel, receive appropriate care in a health emergency. It seeks to improve all aspects of children's acute emergency medical care, including pre-hospital care, emergency department care, hospital care, and rehabilitation, and it seeks to prevent such emergencies from occurring. The EMSC program is the only Federal program that focuses on improving the quality of children's emergency care.

The system for pediatric emergency care has many deficiencies. Fewer than half (46%) of hospitals with emergency departments have the necessary equipment for stabilization of ill and injured children. In 1998, only 5 States required that Advanced Life Support vehicles carry all equipment needed to stabilize a child. Only 11 States have guidelines for acute care facility identification for pediatrics to ensure that children get to the right hospital in a timely manner. Only 40% of U.S. hospitals with

emergency departments have written transfer agreements with a higher level facility to ensure that children receive timely and appropriate hospital care when they need it. Finally, systems are not in place to assess and evaluate pediatric emergency care: only 9 States have the capacity to produce reports on pediatric EMS using Statewide EMS data.

The EMSC program has been a joint effort of HRSA and DOT's National Highway Traffic Safety Administration since its inception in 1985 and has been cited by the Institute of Medicine as an excellent example of government collaboration. The program collaborates with CDC's National Center for Injury Prevention and Control, SAMHSA's Emergency Services and Disaster Relief Branch, and FEMA's Disaster Response Team; and has a close relationship with 14 national organizations representing EMS professionals and other interested groups.

#### **2.14.2 Goal-by-Goal Presentation of Performance**

**Goal IV.C.1 Increase the number of States that have implemented Statewide pediatric protocols for medical direction.** The wording of this performance goal has been changed to emphasize the implementation of Statewide protocols.

**Previous wording: Increase the number of States that have pediatric protocols for both online and offline medical direction.**

**Context:**

Having Statewide pediatric protocols for medical direction within a State will increase the standard of care for pediatric emergency patients.

Indicator: Number of States with Statewide pediatric protocol for medical direction.

**Performance:**

FY 99 Actual Performance of 25 was significantly higher than the FY 99 Target of 18.

**Goal IV.C.2: Increase the number of States that require all EMSC-recommended pediatric equipment on Advanced Life Support (ALS) ambulances.**

**Context:**

Requiring all EMSC-recommended pediatric equipment on Advanced Life Support (ALS) ambulances will increase the quality and appropriateness of care for pediatric emergency patients.

Indicator: Number of States that require all pediatric equipment on ALS ambulances.

**Performance:**

FY 99 Actual Performance of 18 States was significantly higher than the FY 99 Target of 7.

**Data Issues:**

Many of the changes to be accomplished by this program will take some time to accomplish, annual measurement would not show much effect. This is especially true for outcomes, the impact on which will be assessed over five-year periods. On the other hand, the performance measures shown here can and will be assessed annually. An annual reporting form that will be required of grantees is now in preparation for OMB clearance. This form should be available for use by mid-2000.

## **FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report**

### **2.15 Poison Control Centers**

<b>Performance Goals</b>	<b>Targets</b>	<b>Actual Performance</b>	<b>Reference</b>
<b>III. ASSURE QUALITY OF CARE</b> <b>A. Promote Appropriateness of Care</b> 1. Increase the number of uniform and evidence-based guidelines available for approval by the American Association of Poison Control Centers, to be used in Poison Control Centers.	FY 01: 5	FY 01: FY 00: FY 99: 0	B206
<b>Total Funding: Poison Control Centers</b> (\$ in 000's)	FY 2001: \$1,500 FY 2000: \$3,000 FY 1999: n/a FY 1998: n/a	B x: page # budget HP: Healthy People goal	

#### **2.15.1 Program Description, Context and Summary of Performance**

A new program has been initiated in FY 2000 to address problems related to poison control services. FY 2000 funds will be used by HRSA primarily to support the development and assessment of uniform patient management guidelines. This will provide consistent, evidence-based protocols nationally and will result in improved quality of service. This builds on funding allocated in FY 99 by CDC, with support from HRSA, to develop a national toll-free telephone number for poison control and initiate a public education campaign to advertise this number. This will go far to improving access to poison control services nationwide. All activities in support of Poison Control Centers are part of a joint HRSA/CDC initiative. With the exception of the toll-free number, budget requests to support this effort will come through HRSA.

The activities are based on recommendations contained in the Final Report of the Poison Control Center Advisory Group, an ad hoc group called together by HRSA/CDC in response to a request

from HHS to develop a plan to address the poison control center crisis. Their recommendations which are essential to stabilize and improve the system and assure universal access to poison control services form the basis for these proposed activities.

#### **2.15.2 Goal-by-Goal Presentation of Performance**

**Goal III.A.1: Increase the number of uniform and evidence-based guidelines available for approval by the American Association of Poison Control Centers, to be used in Poison Control Centers.**

**Context:**

Having evidenced-based guidelines available for use at the Poison Control Centers will improve the standard of care for acute poisoning-related incidents, thereby improving the quality of care.

**Data Issues:**

Most data will be collected from annual applications and reports from grantees.

**FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report**

**2.16 Program Title: Abstinence Education Program - Title V**

Performance Goals	Targets	Actual Performance	Reference
<b>I. ELIMINATE BARRIERS TO CARE</b> <b>C. Focus on Target Population</b> 1. Achieve State-set targets for reducing the proportion of adolescents who have engaged in sexual intercourse.	FY 01 (06/00)	FY 01: FY 00: FY 99: (01/01) FY 98: (06/00)	B208
2. Achieve State-set targets for reducing the incidence of youths 15-19 years old who have contracted selected sexually transmitted diseases in 50 percent of the participating States.	FY 01: (06/00)	FY 01: FY 00: FY 99: (01/01) FY 98: (06/00)	B208
3. Achieve State-set targets for reducing the rate of births to teenagers aged 15-17 in 50 percent of the participating States.	FY 01: (06/00)	FY 01: FY 00: FY 99: (01/01) FY 98: (06/00)	B208
<b>Total Funding: Abstinence Education Program</b> (\$ in 000's)	FY 2001: \$50,000 FY 2000: \$50,000 FY 1999: \$50,000 FY 1998: \$50,000	B x: page # budget HP: Healthy People goal	

**2.21.1 Program Description, Context and Summary of Performance**

This program provides formula grants to the States for the purpose of providing abstinence education, and at the option of the State, where appropriate, mentoring, counseling, and adult supervision to promote abstinence from sexual activity, with a focus on those groups which are most likely to bear children out of wedlock.

The trends over the past several decades show that increasing proportions of teens have had sexual intercourse. Sexual experience, and particularly the age at first intercourse, represent critical indicators

of the risk of pregnancy and sexually transmitted diseases. After years of increases, the teen birth rate declined by 16 percent from 1991 to 1997, with all States reporting a decline in the birth rate of teens 15-19 years old between 1991 and 1997, according to the Centers for Disease Control and Prevention. The proportion of students who had sexual intercourse also fell 11 percent during the 1990's. Despite these recent declines, teen pregnancy and out-of-wedlock sexual activity remain significant problems in communities across the country.

The Abstinence Education Grant Program is a key component of the National Strategy to Prevent Teen Pregnancy announced by Secretary Shalala in January 1997. This Strategy presented a comprehensive plan to prevent teen pregnancies in the United States by strengthening, integrating, and supporting teen pregnancy prevention and other youth-related activities in communities across the country. The Department of Health and Human Services is committed to involving a wide range of partners in its teen pregnancy prevention efforts, including national, State, and local organizations; schools; health and social service organizations; business; religious institutions; tribes and tribal organizations; federal, State and local governments; parents and other family members; and teens themselves. In communities around the country, there is increasing recognition that helping teens to avoid pregnancy requires multiple programs and strategies. Since the causes of teen pregnancy are complicated and overlapping, solutions must have many parts and approaches.

Established by The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, and first funded in fiscal year (FY) 1998, the Abstinence Education Grant Program is still in its early stages. The annual applications for the program, due in July of each calendar year for the next FY, will report data for the preceding FY. Data for the first year of operation, FY 1998, will be reported in the applications received in July 1999, and should be processed and available by June 2000.

The Department, through the Office of the Assistant Secretary for Planning and Evaluation (ASPE), is responsible for conducting an evaluation of the State Abstinence-only Education Grants. There were no provisions made in the original legislation for a Federal evaluation of the Abstinence Education Grant Program. The Balanced Budget Act of 1997 set aside funding for Federally-sponsored evaluations of Section 510 abstinence-only education programs. In August 1998, Mathematica Policy Research was awarded the contract of the Evaluation of Abstinence-only Education Programs. This project is a three-year multi-site effort to improve knowledge about programs aimed at preventing teen sexual activity and its negative consequences. The evaluation will focus on nine sites involving random assignment experiments and, possibly, five sites involving comprehensive community-wide initiatives. Data collection was scheduled to begin in the fall of 1999.

The proportion of States who met their individual objectives for FY 1998 for the three specified performance measures has not presently been compiled. It is anticipated that the data for States who reported an FY 1998 performance indicator for the specified measures in their FY 1998 annual report will be compiled by June 2000. "The national targets for FY 2001 will be set when the baselines for FY 1998 become available in June 2000."

### **2.21.2 Goal-by-Goal Presentation of Performance**

#### **Goal I.C.1: Achieve State-set targets for reducing the proportion of adolescents who have engaged in sexual intercourse in 50 percent of the participating States.**

Nationwide, approximately 53% of all high school students have had sexual intercourse during their lifetime. There are some indications that early sexual intercourse by adolescents can have negative effects on social and psychological development. Abstinence-only education programs are a way to educate young people and create an environment within communities that support teen decisions to postpone sexual activity.

Baseline: June 2000

Performance FY 1999: January 2001

Target FY 2001: June 2000

Indicator: The percentage of participating States that achieve State-set targets.

#### **Goal I.C.2: Achieve State-set rates for reducing the incidence of youths 15-19 years old who have contracted selected sexually transmitted diseases (STDs) in 50 percent of the participating States.**

STDs are preventable diseases and the availability and quality of sexually transmitted disease services are important factors in preventing the spread of disease and complications. The majority of STDs occur in people aged 15-29 years. By age 21, approximately 1 of every 5 young people has required treatment for an STD. Primary and secondary prevention approaches are effective ways to reduce STDs. Abstinence-only education programs are one way to educate young people regarding the relationship of sexual activity and STDs.

Baseline: June 2000

Performance FY 1999: January 2001

Target FY 2001: June 2000

Indicator: The percentage of participating States that achieve State-set targets.

#### **Goal I.C.3: Achieve State-set targets for reducing the rate of births to teenagers aged 15-17 in 50 percent of the participating States.**

Teen pregnancy is a major threat to healthy and productive lives. Teen parenting is associated with the lack of high school completion and initiating a cycle of poverty for mothers.

Baseline: June 2000

Performance FY 1999: January 2001

Target FY 2001: June 2000

Indicator: The percentage of participating States that achieve State-set targets.

**Data Collection and Validation:**

Data for all performance measures will be reported in the annual formula grant applications. These applications, due in July of each calendar year for the next fiscal year (FY), report data for the preceding FY. Data for the first year of operation, FY 1998, as reported in July 1999, will be processed and available by June 2000.

**Data Limitations and Planned Improvements:**

The States do not all have good data for some measures related to teenage sexual behaviors, so there may be some difficulty in obtaining high quality data in the early stages of this program. Every effort will be made to work with the States to improve the quality of their data as quickly as possible. In addition, not all States were able to report annual performance indicators for FY 1998 in their FY 1998 annual reports. It is anticipated that an increased number of States will be able to report FY 1998 annual performance indicators in their FY 1999 annual reports.

## **HEALTH PROFESSIONS**

### **FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report**

The mission of the Bureau of Health Professions (BHP) is to contribute to ensuring access to quality health care for all Americans by supporting education and training programs that improve the diversity, distribution, and quality of the health care workforce. Through a collection of programs and activities, the Bureau strives to improve the health status of all Americans, particularly the underserved, by enhancing the education, utilization, training, diversity, and quality of the Nation's health personnel.

Through Titles VII and VIII programs, the Bureau provides both policy leadership and support for health professions workforce enhancement and educational infrastructure development. Current emphasis is on improving the geographic distribution and diversity of the health professions workforce. The Bureau utilizes an outcome-based performance system to measure whether program support is meeting its national health workforce objectives, and to signal where program course correction is necessary.

Programs included in this section include:

- 2.17 Health Professions and Nursing Training Programs
- 2.18 Workforce Information and Analysis
- 2.19 Children's Hospital Graduate Medical Education
- 2.20 Health Education and Assistance Loans (HEAL)
- 2.21 National Practitioner Data Bank,  
Healthcare Integrity and Protection Data Bank
- 2.22 Vaccine Injury Compensation Program
- 2.23 Ricky Ray Hemophilia Relief Fund Program

**FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report**

**2. 17 Program Title: Health Professions and Nursing Education and Training Programs**

<b>Performance Goals</b>	<b>Targets</b>	<b>Actual Performance</b>	<b>Reference</b>
<b>I. ELIMINATE BARRIERS TO CARE</b> <b>A. Increase Utilization for Underserved Populations</b> 1. Increase the number of students/trainees in clinical training with health care service delivery organizations serving underserved areas	FY 01: 33,580 FY 00: 33,580 FY 99: 31,575	FY 01: FY 00: FY 99: 11/00 FY 98: 26,347	B137
2. Increase the number of graduates and/or program completers who enter practice in underserved areas	FY 01: 5,789 FY 00: 4,467 FY 99: 4,391	FY 01: FY 00: FY 99: 11/00 FY 98: 5,374	B137
3. Increase the number of graduates and/or program completers of health professions primary care tracks and programs that support primary care	FY 01: 46,637 FY 00: 68,232 FY 99: 68,350	FY 01: FY 00: FY 99: 11/00 FY 98: 69,786	B137
<b>II. ELIMINATE HEALTH DISPARITIES</b> <b>B. Increase Utilization for Underserved Populations</b> 1. Increase the number of minority/disadvantaged graduates and program completers	FY 01: 12,814 FY 00: 12,035 FY 99: 10,652	FY 01: FY 00: FY 99: 11/00 FY 98: 8,092	B137
2. Increase the number of minority/disadvantaged enrollees.	FY 01: 19,162 FY 00: 21,286 FY 99: 21,231	FY 01: FY 00: FY 99: 11/00 FY 98: 16,391	B137

Performance Goals	Targets	Actual Performance	Reference
3. Increase the number or underrepresented minorities serving as faculty	FY 01: 119 FY 00: 334 FY 99: 326	FY 01: FY 00: FY 99: 11/00 FY 98: 240	??
<b>Total Funding: Health Professions and Nursing Training Programs</b> (\$ in 000's)	FY 2001: \$217,245 FY 2000: \$301,193 FY 1999: \$301,177 FY 1998: \$289,101	B x: page # budget HP: Healthy People goal	

### **2.17.1 Program Description, Context and Summary of Performance**

#### **Context:**

Titles VII and VIII of the Public Health Service Act create programs to support the education and training of the healthcare workforce. The programs consist of competitive grants to organizations that train and educate healthcare professionals. Current efforts are focused on improving the geographic distribution and diversity of the healthcare workforce.

The BHPr exercises policy leadership and support for enhancing the health professions workforce and educational infrastructure. This is accomplished through administration of approximately 40 grant programs to educate and train physicians, nurses, dentists, allied health professionals and public health practitioners at approximately 1,700 institutions. BHPr personnel also maintain extensive professional relationships with numerous professional organizations concerned with health care so the programs respond quickly to evolving needs. Most grants are awarded on the basis of peer-reviewed applications to assure the highest standards of professional competence and objectivity. To assure maximum availability of information to our customers, the Bureau/Agency maintains a Web site that provides information about the Bureau/Agency, grants to be awarded in the upcoming grant cycle and materials with which to apply for a grant.

Within HRSA, the Bureau of Health Professions provides funds to the Bureau of Primary Health Care (BPHC) to support managed care fellowship activities and to Maternal and Child Health Bureau for faculty development of generalist physicians. BHPr also supports HRSA's Border Health Initiative to carry out an outreach project in four border states to train local residents as community health workers, encourage health promotion, and reach out to families

to enroll children for the Child Health Insurance Program. Finally, BHPr sponsors the revitalization of Primary Care Week through efforts of the AHEC Program, Family Medicine professional associations, student associations (AMSA) and other collaborating partners.

**Program-wide performance:**

The grant programs are proven successes in filling gaps left by the healthcare marketplace. For instance, while only 10% of all U.S. healthcare graduates practice in medically underserved communities, a sampling of Bureau funded programs shows 40% for Professional Nurse Traineeships, 40% for Nurse Practitioner/Midwife, and 33% for Family Practice residency practice in these areas. The goal of graduating healthcare professionals from underrepresented racial/ethnic backgrounds is similarly well-advanced by Title VII and VIII programs. Whereas the average graduating cohort of healthcare professional schools in the U.S. is composed of approximately 10% underrepresented minorities, Bureau funded programs are well targeted to achieve program objectives of graduating underrepresented minorities: 89% for the Faculty Loan Repayment Program, 50% for the Scholarships for Disadvantaged Students Program, 32% for Physician Assistant Training, 21% for Advanced Nurse Education and 19% for Preventive Medicine Residencies.

**Program-level data issues:**

The goals presented in Section 2.22.2 capture the significant output on Bureau goals concerning access to health care and the diversity, distribution and quality of the healthcare workforce which cut across all Title VII and VIII programs. The goals provide useful information to identify program strengths and areas that need technical assistance to better meet program objectives. The Bureau has relied on data collected from grantees, but lacked a unified approach to the collection activity. In July 1994, BHPPr began developing a structured, agency-wide strategic approach to collecting performance data on Title VII and VIII health professions and nursing training and education programs. Through the assistance of outside contractors and a panel of external advisors, the agency set goals and designed a system to capture performance data. The Comprehensive Performance Management System (CPMS) is the result of this multi-year effort.

A demonstration project of the CPMS in 1998 showed that it was both feasible and desirable to capture the qualitative and quantitative information in a more streamlined manner. We also learned that designing a form that is both easy to use and sufficiently comprehensive to capture information on approximately 40 programs presents unique challenges. The first nation-wide collection of CPMS performance data from all grantees was for the period July 1, 1997 - June 30, 1998. It was completed in the Spring of 1999 and the data became available in December 1999.

Data for that year is the basis for most of the data in the FY 98 Actual Performance column on the tables presented below. The first year's data from CPMS, while confirming that the overall approach in developing the CPMS is sound, disclosed several problems in how BHPPr implemented the system. As a result, the performance data shown, while mostly based on CPMS, had to be supplemented by imputing data for grantees who did not report or other estimating techniques. In some instances we used data from other sources when the reported CPMS data was obviously incorrect.

Our analysis of the problems have led the BHPPr to initiate corrective action to prevent recurrence from

adversely affecting the quality of the data being collected for the performance year July 1, 1998 - June 30, 1999. Those data will be reported in the FY 99 Actual Data column in the next Annual Performance Plan. That data is expected to be available in November 2000.

We expect to have a fully automated version of the CPMS developed, tested and on line in time to begin the collection of FY 2000 data in October 2000. That automated version will further reduce the incidence of error both from grantees and data transcription and make the data that much more accurate and the collection more efficient.

## **2.17.2 Goal-by-Goal Presentation of Performance**

### **Goal I. A. 1: Increase the Number of Students/trainees in Clinical Training with Health Care Service Delivery Organizations Serving Underserved Areas.**

#### **Context:**

One major reason why approximately 40 million Americans do not have access to healthcare is that physicians, dentists, nurses and other health professionals are not distributed evenly throughout the population. The uneven distribution is particularly problematic in rural and inner city areas. The healthcare students funded through Title VII and VIII programs provide basic healthcare services to underserved populations as part of their training. The number of student/trainees in clinical training with health care service delivery organizations serving underserved provides an indicator of the extent to which health education programs help meet the needs of the underserved.

**Performance:**

	Targets			Actuals	
	FY01	FY00	FY99	FY 99 available 11/00	FY 98
Rural Interdisciplinary	1,300	1,300	1,300		1,365
HETC	280	280	275		279
AHEC	32,000	32,000	30,000		24,703
<b>Total</b>	<b>33,580</b>	<b>33,580</b>	<b>31,575</b>		<b>26,347</b>

Area Health Education Centers (AHECs) are exceptionally productive in terms of training health professionals in underserved areas. In FY 1998, AHECs provided about 25,000 health professions students a training experience in underserved areas. AHEC underserved training sites included 525 Community Health and Migrant Health Centers. Of the 144 U.S. medical schools, 112 participate in the AHEC program. Health Education Training Centers (HETCs) focus on training health profession students in underserved areas along the U.S. Mexico border and in Florida. In addition to training approximately 280 health professions students per year, the HETCs are training 130 local residents as community health workers. The (Quentin N. Burdick Program for) Rural Interdisciplinary Training program trains health professionals in underserved rural areas. The Rural Program slightly exceeded its goal for 1998, providing a rural interdisciplinary training experience to 1,365 health professionals.

**Goal I. A. 2: Increase the Number of Graduates and/or Program Completers Who Enter Practice in Underserved Areas**

**Context:**

There are several common strategies for encouraging graduates to enter practice in medically underserved communities (MUC). Among them are: providing didactic training to prepare students for practice in MUCs, interaction with faculty role models who serve in MUCs and placement services for practicing in such areas. In addition, studies have shown that healthcare practitioners have a higher likelihood of locating in underserved areas if they spend part of their training providing for the health needs of the underserved. Regardless of the strategy selected, one clear indicator of success for Titles VII and VIII programs is the number of graduates and/or program completers who enter practice in underserved areas.

**Performance:**

	Targets			Actuals	
	FY01	FY00	FY99	FY99 available 11/00	FY98
Allied Health Spcl Projects	689	1,007	922		1,164
Advanced General and Pediatric Dentistry	--	92	86		118
Health Administration	--	630	630		480
Dental Public Health	--	4	4		11
Rural Interdisciplinary	650	650	650		630
Public Health Trng Cntr (Short Term)	3,200	---	---		---
Preventive Medicine	--	11	11		11
Family Medicine - Grad Trng	--	303	312		450
Physician Asst Trng	--	406	410		527
Advanced Nurse Education	140	140	140		323
Nurse Practitioner/Midwife	230	230	230		425
Prof'l Nurse Traineeship	880	880	880		1,012
General Internal Med PED/GT	—	107	109		202
Podiatry	--	7	7		21
<b>TOTAL</b>	<b>5,789</b>	<b>4,467</b>	<b>4,391</b>		<b>5,374</b>

The Health Professions Training Programs are exceptionally effective in improving access for the underserved. The HRSA-supported training program targets (goals) for graduates practicing in underserved areas are 2.5 to 5.0 times higher than the National average. Programs with goals of 40% or higher include Allied Health Special Projects, Family Medicine Graduate Training, Public Health Traineeships, and the Health Administration Program. Overall, FY98 actual performance data indicate that the program goals were exceeded. In particular, FY98 performance substantially exceeded FY99 goals for: Advanced Education Nursing (the target was 35% and the actual was 52%), Nurse Practitioner/Midwife (the target was 35% and the FY98 actual was 46%), Professional Nurse Traineeships (the target was 40% and the FY98 actual was 45%), and Physician Assistant Training (the target was 26% and the FY98 actual was 32%). The exceptional performance of these four programs is largely attributed to a funding strategy used whereby funding preference is given to schools with a good track record for graduates practicing in underserved areas.

FY98 actuals were significantly higher (25 percent or more) than FY99 targets for Advanced General and Pediatric Dentistry, Family Medicine Graduate Training, General Internal Medicine/Ped Graduate Training, and Podiatry.

Because of funding differences between the FY 2000 *President's Budget* and the *Consolidated*

*Appropriations Act of 2000*, performance targets were revised to reflect the differences. These performance targets also reflect the phasing out of several Health Professions grants (i.e., Primary Care Medicine and Dentistry), because Federal efforts have demonstrated their effectiveness and are now shifted to other activities, such as improving access to care in rural and underserved communities and increasing opportunities for individuals from minority/disadvantaged backgrounds.

**Goal I. A. 3: Increase the Number of Graduates and/or Program Completers of Health Professions Training Programs that Provide and Support Primary Care**

**Context:**

Title VII and VIII education and training programs are designed to improve the geographic distribution and diversity of the health professions and nursing. The number of graduates and/or program completers provides a basis for evaluating the effectiveness of these programs in improving distribution and diversity. Performance targets were also changed to reflect changes in funding for specific program lines.

**Performance:**

	Targets			Actuals	
	FY01	FY00	FY99	FY 99 11/00	FY98
<b>Long-Term Training</b>					
Family Medicine - Fac.Dev.	--	53	53		116
Family Medicine - Grad Trg	--	759	774		859
GIM/Ped Res	--	414	423		390
GIM/GP Faculty Dev	--	101	103		44
Physician Asst Trng	--	1,561	1,595		1,254
Allied Health Spec Pro	1,378	2,014	2,050		2,050
Interdisciplinary Rural Hlth	1,300	1,300	1,300		1,448
Advanced General & Pediatric Dentistry	--	282	262		212
Public Health Traineeships	--	516	516		510
Preventive Medicine	--	31	31		41
Dental Public Health	--	15	15		11
Health Administration	--	400	400		399
Podiatry	--	20	20		60
Advanced Nurse Educ	400	400	400		497
Prof'l Nurse Traineeships	2,200	2,200	2,200		2,248
Nurse Pract/Midwife	660	660	660		923
Scholarships for Disad- vantaged Students (SDS)	3,119	3,119	3,119		2,023
<b>Total - Long Term</b>	<b>6,357</b>	<b>13,845</b>	<b>13,921</b>		<b>13,085</b>
<b>Short-Term Training</b>					
AHEC	32,000	32,000	30,000		26,859
Family Medicine/Faculty Development (Short)	--	2,034	2,079		937
GIM/GP Faculty Development (Short)	--	73	75		258
Geriatric Programs	--	20,000	20,000		28,383
HETC	280	280	275		264
Public Health Trng Cnter	8,000	---	---		----
<b>Total - Short-Term</b>	<b>40,280</b>	<b>54,387</b>	<b>52,429</b>		<b>56,701</b>
<b>TOTAL</b>	<b>46,637</b>	<b>68,232</b>	<b>68,350</b>		<b>69,786</b>

On average, long- and short-term primary care training targets were met in FY98. In total, the FY98 actual exceeded the targets for FY99 through FY01. The performance of the Geriatric program is especially noteworthy. The Geriatric program is the major source of training for health professionals

to care for the elderly. The Geriatric program FY99 training target of 20,000 health professionals was exceeded in FY98 by 42%.

Actual FY98 performance were significantly higher (25 percent or more) than performance targets for Family Medicine Faculty Development and General Internal Medicine/General Pediatric Faculty Development.

Scholarships for Disadvantaged Students: This program now includes funding that was previously made available as Exceptional Financial Need Scholarships and Financial Assistance for Disadvantaged Health Professions Students. As a result of consolidating these programs into the SDS program, the targets for FY99 through FY01 were increased from 2,400 to 3,100.

Because of funding differences between the FY 2000 *President's Budget* and the *Consolidated Appropriations Act of 2000*, performance targets were revised to reflect the differences. These performance targets also reflect the phasing out of several Health Professions grants (i.e., Primary Care Medicine and Dentistry), because Federal efforts have demonstrated their effectiveness and are now shifted to other activities, such as improving access to care in rural and underserved communities and increasing opportunities for individuals from minority/disadvantaged backgrounds.

## **Goal II B. 1: Increase the Number of Minority/disadvantaged Graduates and Program Completers**

### **Context:**

Studies have shown that members of minorities and disadvantaged groups are more likely to set up practices which address the needs of the underserved. The number of minority/disadvantaged graduates and program completers provides an important indicator of the success of Title VII and VIII programs in assuring progress toward a diverse health-care workforce to meet the needs of a diverse population.

### **Performance:**

	Targets			Actuals	
	FY01	FY00	FY99	FY99 (11/00)	FY98
Scholarships for Disadvantaged Students	3,473	3,473	3,473		2,357
GIM/GP Residency	--	123	126		167
GIM/GP Fac Dev Trainees	--	22	23		69
General Dentistry/Ped Dent	--	70	66		105
HCOP					
Post-Secondary	5,077	4,680	4,365		3,270
K - 12	2,516	2,075	900		1,098
Fam Med - Graduate Trng	--	136	138		297
Fam Med - Fac Dev Trainee	--	208	213		135
Podiatry	--	6	6		9
Physician Assistant	--	562	580		451
Allied Health	248	363	369		N.A. 1/
Public Health Traineeships	--	236	236		N.A. 1/
Preventive Medicine	--	11	11		N.A. 1/
Dental Public Health	--	6	6		8
Public Health training Center	1,500	---	---	---	N.A. 2/
Health Admin Traineeships	---	70	70		126
<b>TOTAL</b>	<b>12,814</b>	<b>12,035</b>	<b>10,652</b>		<b>8,092</b>

1/ N.A.: Not Available

2/ New Program—First Performance Data Available in FY01

FY98 performance of over 16,000 minority/disadvantaged enrollees exceeded the original FY99 target of 9,000 by 78%. As a result, several programs increased their FY99 through FY01 targets: SDS (tripled target), Nurse Practitioner/ Midwife (doubled target), Professional Nurse Traineeships (quintupled target), Nursing Education Opportunity (quintupled target), and Advanced Nurse education (doubled target). FY98 actuals were significantly higher (25 percent or more) than FY99 targets for: General Internal Medicine and Pediatric Residencies, General Internal Medicine and Pediatric Faculty Development, General Dentistry and Pediatric Dentistry, and Family Medicine Graduate Training.

## **Goal II.B. 2: Increase the Number of Minority/disadvantaged Enrollees**

**Context:**

The goal of a diverse healthcare workforce is dependent, in part, on the number of young people minority/disadvantaged students who are motivated in elementary school and high school to succeed in the academically challenging work required for admission to health-care education. BHP<sub>r</sub> has initiated several outreach initiatives to encourage such students in elementary and high school and help them to see health professions as a realistic career choice. The number of minority/disadvantaged enrollees is an indication of success in assuring a prerequisite to a diverse workforce - minority/disadvantaged students choosing it as a career.

**Performance:**

	Targets			Actuals	
	FY01	FY00	FY99	FY99 Available 11/00	FY98
Scholarships for Disadvantaged Students	13,892	13,892	13,892		9,430
Nurse Practitioner/Midwife	500	500	500		567
Professional Nurse Traineeships	1675	1,675	1,675		1,686
Nursing Education Opportunity	1,500	1,500	1,500		1,597
Podiatry	0	6	6		5
Family Medicine - Grad Trng	--	416	416		449
Family Medicine - Fac Dev	--	208	213		48
GIM/Ped	--	381	381		248
GIM/GP Faculty Dvlpmnt	--	22	23		40
Physician Assistant Trng	--	1170	1,170		841
HCOP (Matriculants)	1015	936	880		800
HETC	280	280	275		264
Advanced Nurse Education	300	300	300		416
<b>TOTAL</b>	<b>19,162</b>	<b>21,286</b>	<b>21,231</b>		<b>16,391</b>

FY98 performance of over 16,000 minority/disadvantaged enrollees exceeded the original FY99 target of 9,000 by 78%. As a result, several programs increased their FY99 through FY01 targets: SDS (tripled target), Nurse Practitioner/ Midwife (doubled target), Professional Nurse Traineeships (quintupled target), Nursing Education Opportunity (quintupled target), and Advanced Nurse education (doubled target).

Data on minority/disadvantaged enrollees, like graduates, was not readily available for some grantees.

Grantees are now required to collect data on minority/disadvantaged graduates and students and it is anticipated that data collection will be improved this year. Performance targets were also changed to reflect changes in funding for specific program lines.

### **Goal II.B.3: Increase the Number of Underrepresented Minorities Serving as Faculty**

#### **Context:**

There is mounting awareness that the effectiveness of the healthcare workforce is dependent on its sensitivity to the cultural differences which affect healthcare. The composition of the healthcare workforce should reflect, in general, the characteristics of the general population. Faculty members who are from underrepresented minorities have unique insights into the cultural component of healthcare and provide role models for future healthcare workers from underrepresented minority groups. The number of underrepresented minorities serving as faculty provides an indicator that is useful in monitoring several issues.

#### **Performance:**

	Targets			Actuals	
	FY 01	FY00	FY99	FY 99 Available 11/00	FY 98 Available 11/99
Loan Repayments and Fellowships regarding Faculty Positions	34	34	44		18
Family Medicine Faculty Development Trainees	--	208	213		107
General Internal Med/Pediatrics - Faculty Devel. Trainees	--	22	23		71
Centers of Excellence - URM faculty	85	70	46		44
<b>TOTAL</b>	<b>119</b>	<b>334</b>	<b>326</b>		<b>240</b>

Several programs contribute to diversifying the faculty at health professions schools. Data is not yet available for two of the programs and not all grantees reporting had data on the number of

underrepresented faculty supported with health professions training grants. Grantees are now required to collect and report data on underrepresented faculty and it is anticipated that data collection will be improved this year.

Because of funding differences between the FY 2000 *President's Budget* and the *Consolidated Appropriations Act of 2000*, performance targets were revised to reflect the differences.

## **FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY1999 Performance Report**

### **2.18 Program Title: Health Professions Workforce Information and Analysis**

<b>Performance Goals</b>	<b>Targets</b>	<b>Actual Performance</b>	<b>Reference</b>
<b>IV. IMPROVE PUBLIC HEALTH AND HEALTH CARE SYSTEMS</b> <b>A. Improve Information Development and Dissemination</b> 1. Increase the number of states that are being provided technical assistance in the use of workforce requirements, supply models and other workforce tools and analyses. (Revised)	FY 01: 5 FY 00: 5 FY 99: 5	FY 01: FY 00: FY 99: 5 FY 98: 4	B166
2. Annually produce results of data collection and analysis activities conducted to inform the market regarding issues relevant to health professions and nursing workforce.	FY 01: 10 reports FY 00: 7 FY 99: 5	FY 01: FY 00: FY 99: 5 FY 98: 2 reports	B166
<b>Total Funding: Workforce Information and Analysis</b> (\$ in 000's)	FY 2001: \$714 FY 2000: \$714 FY 1999: \$714 FY 1998: \$686	B x: page # budget HP: Healthy People goal	

#### **2.18.1 Program Description, Context and Summary of Performance**

**Context:**

About 15 cents of every dollar spent in the U.S. is on health care and one out of every 12 jobs (and growing) is in the health care industry. In spite of the magnitude of expenditures and employment in the health care industry, excepting physicians, relatively little is known of the health care workforce. For example, while public health is one of the most fundamental Federal, state and local government functions—responsible for addressing health care issues that account for 50 percent of all preventable deaths—there is no data available on the public health workforce. In the absence of data on the public health workforce, it is impossible to assess public health workforce needs versus supply, distribution, and training needs.

The investment in workforce information and analysis will result in more efficient allocation of resources and greatly reduce the Federal, State, and private expenditures in health care. For example, better information on the impact of health professional training on practice in underserved areas will result in better distribution of health care providers and lower Federal subsidies in health professionals education.

In recent years, health policymakers and groups of experts have advocated for a strong Federal government role in developing information and conducting analyses on health workforce supply, requirements, and distribution. Two such reports include findings from the Institute of Medicine (IOM): Primary Care: America's Health in a New Era, March 1996 and The Nation's Physician Workforce: Options for Balancing Supply and Requirements, February 1996. Many state and local governments have also voiced this need through numerous requests for assistance in analyzing their health workforce supply and requirements.

The Health Professions Workforce Information and Analysis program plays a critical role in ensuring health care access for the Nation. The goals of the program are to: (1) provide health workforce information and analyses to national, State, and local policy makers and researchers on a broad range of issues such as graduate medical education, Medicaid/CHIP, and health care workforce planning and (2) conduct Federal-State collaborative efforts directed at assessing the adequacy of the current and future local health care workforce and develop strategies for improving the diversity and distribution of their respective workforces.

A network of Federal/State Centers for health workforce research is being developed to forecast local health workforce supply and requirements. The following high-priority activities will be conducted with the proposed funding:

- C Continued support of one Regional Center (or Center of Excellence). Working with the appropriate State officials, the Regional Center develops methodologies to: study local trends

in the supply and distribution of physicians, dentists, nurses, allied health and public health professionals; identify areas having localized shortages of these professionals; identify the causes of these shortages; and develop strategies for addressing the problem.

- C Update health workforce data for those health professions that are currently on the Area Resource File (ARF) (the single most comprehensive health professions workforce database).
- Expand and adapt workforce requirement models for use at the state and local level to assess health care workforce issues and provide associated technical assistance.

The primary partners and customers are: 1) HRSA and the Bureau of Health Professions; 2) National policy makers and advisory councils such as the Congress, Council on Graduate Medical Education, National Advisory Council on Nurse Education and Practice, National Governors Association, National Conference of State Legislatures; 3) State policy makers and advisors such as State Health Departments and Primary Care Offices and Associations; and 4) the health policy research community such as PEW Health Professions Commission, Robert Wood Johnson Foundation, and academic research centers.

#### **Program-wide performance:**

The Area Resource File, the ARF, is the only comprehensive health workforce data base in existence. It is widely used by other Federal agencies (including: HCFA, AHRQ, NCHS, NIH, and SAMSHA), state and local agencies and the private sector. The regional Center of Excellence for Health Workforce Information and Analysis is very productive and conducts very topical studies that have wide ranging implications. For example, one such study examined the impact of anti-affirmative action legislation on minority enrollment in medical schools in the State of California. The study has implications for other States where anti-affirmative action legislation has been passed or considered and, more broadly, implications for the diversity of the health workforce in the country. The number of these policy-relevant studies is anticipated to increase 5-fold from 1998 to 2001. To aid national and state policymakers, models were also developed and refined to estimate requirements for physicians, nurse practitioners, and physician assistants. Extensive technical assistance in using these models was provided to 4 states.

#### **2.18.2 Goal-by-Goal Presentation of Performance**

##### **Goal IV.A.1: Increase the number of states that are being provided technical assistance in the use of workforce requirements, supply models and other workforce tools and analyses.**

The goal targets and actual performance were revised to reflect the level of appropriated funding.

**Context:**

Health workforce requirement models, tools, and analysis are needed by States for planning health professionals education, to assess access issues, and in planning to meet future health care needs.

**Performance:**

The baseline reflects current performance and the targets are based on program planning estimates. The number of states that provided technical assistance indicates the breadth of use of the workforce tools developed under this program.

**Goal IV.A.2: Annually produce results of data collection and analysis activities conducted to inform the market regarding issues relevant to health professions and nursing workforce.**

**Context:** Workforce analysis is needed to plan and implement the Bureau's health professions training programs. It is also needed by other HRSA programs, the Health Care Finance Administration, the Council on Graduate Medical Education, Federal and State and local policymakers, health policy research organizations, and professional associations.

**Performance** The number of health workforce analyses conducted is an indicator of the number of workforce issues analyzed and a measurement of the applied, relevant nature of the program. In addition to developing tools, the National Center for Health Workforce Information and Analysis also conducts research on topical or current workforce issues and compiles data and descriptive reports on the health professions. These important products are used by a wide range of healthcare planners, policy analysts, students, and researchers. The goal targets and actual performance were revised to reflect the level of appropriated funding.

**FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY1999 Performance Report**

**2.19 Program Title: Children's Hospital Graduate Medical Education Program**

<b>Performance Goals</b>	<b>Targets</b>	<b>Actual Performance</b>	<b>Reference*</b>
<b>I. Eliminate Barriers to Care</b> <b>A. Increase Utilization for Underserved Populations</b> 1. Maintain the number of FTE residents whose training is supported by the grantee children's hospital. (Developmental)	FY 01: Not established FY 00: Not established FY 99: NA	FY 01: FY 00: FY 99: NA	B175
2. Maintain the percentage of residents' training that is supported in rural and medically underserved areas. (Developmental)	FY 01: Not established FY 00: Not established FY 99: Not applicable	FY 01: FY 00: FY 99: NA	B175
<b>II ELIMINATE HEALTH DISPARITIES</b> <b>B. Increase Utilization of for Underserved Populations</b> 1. Improve Percentage of minority residents. (Developmental)	FY 01: Not established FY 00: Not established FY 99: Not applicable	FY 01: FY 00: FY 99: NA	B175

Performance Goals	Targets	Actual Performance	Reference*
<b>IV IMPROVE PUBLIC HEALTH AND HEALTH CARE SYSTEMS</b> <b>A. Improve Information Development and Dissemination</b> 1. Monitor financial status of hospitals (total and operating margins). (Developmental)	FY 01: Not established FY 00: Not established FY 99: NA	FY 01: FY 00: FY 99: NA	B175
2. Monitor the proportion of uncompensated care patients. (Developmental)	FY 01: Not established FY 00: Not established FY 99: NA	FY 01: FY 00: FY 99: NA	B175
3. Monitor the proportion of Medicaid patients. (Developmental)	FY 01: Not established FY 00: Not established FY 99: NA	FY 01: FY 00: FY 99: NA	B175
<b>B. Promote Education and Training of the Public Health and Health Care Workforce</b> 1. Improve the percentage of graduated residents passing their board exams on the first attempt. (Developmental)	FY 01: Not established FY 00: Not established FY 99: NA	FY 01: FY 00: FY 99: NA	B175
<b>Total Funding: Children's Hospital Graduate Medical Education</b> (\$ in 000's)	FY 2001: \$80,000 FY 2000: \$40,000 FY 1999: 0	B x: page # budget HP: Healthy People goal	

### **2.19.1: Program Description, Context and Summary of Performance**

#### **Context:**

Under the formulas to fund children's teaching hospitals, approximately 59 hospitals that have their own provider number, receive little compensation from Medicare for graduate medical education (GME) and other health professions training. As managed care organizations become increasingly unwilling to pay for GME, the lower level of Medicare support puts an undue burden on these hospitals in competing for private and Medicaid managed care contracts. In the absence of commensurate support for direct medical education, freestanding children's hospitals will have an increasing incentive to reduce the number of pediatric residents and services provided to their communities. The Children's Hospital Graduate Medical Education Program makes the level of support more consistent with other teaching hospitals so that the level of training in children's hospitals keeps pace with the need.

Payments for direct graduate medical education activities are determined by a formula based on a standardized per resident amount that takes into account wage and non-wage related portions. Payments will also be provided for indirect graduate medical education purposes and will take into account the case-mix index for a children's hospital. Payments will support the training of resident physicians as defined by Medicare in both ambulatory and inpatient settings.

This program is designed to augment the minimal funding provided by Medicare for graduate medical education in freestanding children's hospitals. Coordination with HCFA will continue throughout the development and administration of the program. We continue to work closely with potential grantees to plan the program and identify information needs.

#### **Program-wide performance:**

This program was not implemented until Fiscal Year 2000 and no performance data will be available until FY 2002.

#### **Program-level data issues:**

FY 2000 is the first year of the program's operation. The program is expected to collect data from participating hospitals which address the financial status of the hospital and various training program measures. During Fiscal Year 1999, the Bureau began working with potential grantees and professional associations to develop performance measures.

### **2.19.2 Goal-by-Goal Presentation of Performance**

These goals are considered developmental. During the first year, an assessment will be made of the feasibility of collecting appropriate data.

### **Goal I.A.1. Maintain the Number of Pediatric Trainees**

#### **Context:**

The health care workforce environment requires that sufficient numbers of physicians be appropriately and adequately trained to care for pediatric populations. As freestanding children's hospitals experience financial pressures common to the academic health center community, there may be increased interest in reducing or eliminating training programs. These hospitals and their training programs provide a significant service to the local, regional and sometimes national community. A reduction in training programs would impact the provision of those services as well as the production of one quarter of the Nation's pediatricians and the majority of pediatric specialists.

These data elements provide an accurate accounting of the number of resident FTEs training in children's hospitals. In addition to performance and trend analysis considerations, these numbers are fundamental to determining the FTE number upon which payments will be made.

#### **Performance:**

This program was not implemented until Fiscal Year 2000 and no performance data will be available until FY 2002. Each hospital will be asked to submit on an annual application the aggregate number of FTE residents who are:

- C In the grantee children's hospital and sponsored by the hospital
- C rotating into the grantee hospital from residency programs sponsored by other institutions
- C sponsored by the grantee hospital and rotating to other hospitals

#### **Goal-level data issues:**

The numbers of trainees in a given hospital's training program is currently collected by the Health Care Financing Administration (HCFA) for those freestanding children's hospitals that opt to request reimbursement from Medicare. Not all freestanding children's hospitals that are eligible for participation in the CHGME Program have submitted such information to HCFA. Generally, each hospital has a fairly good accounting of the number of trainees in its programs. Accounting for the number of trainees rotating to a freestanding children's hospital for a portion of their training is more complicated. A few children's hospitals have begun to quantify the number of trainees rotating to their hospital from other training programs. Hospitals will have to establish the infrastructure to accurately account for trainees eligible to be counted for the purposes of the CHGME Program.

## **Goal IA 2. Increase in the Proportion of Residents Serving Underserved Populations**

**Context:** Access research has focused on the contribution of physicians serving the underserved. Access to care is significantly improved when physicians are serving the underserved. Residency training programs located in rural and MUCs provide much needed care in their communities while residents are learning the knowledge, skills and attitudes necessary to adequately and appropriately care for rural and underserved populations.

### **Performance:**

This program was not implemented until Fiscal Year 2000 and no performance data will be available until FY 2002. Each hospital will be asked to submit on an annual application the proportion of residents training in medically underserved communities (MUCs) and rural areas. The definition for the designation of rural areas shall be adopted from the United States Department of Agriculture's Urban-Rural County Continuum Code classification system. The definition of a MUC shall be consistent with the definitions currently utilized by HRSA.

### **Goal-level data issues:**

Hospitals and their training programs do not routinely report nor calculate information regarding training locations and populations served in residency training programs.

## **Goal II.B.1. Improve Percentage of Minority Residents**

### **Context:**

Numerous studies have demonstrated that increasing the diversity of the physician workforce will improve access to care as underrepresented minorities are more likely to practice in "socioeconomically deprived" areas and to enter generalist specialties.

Communities with high proportions of black and Hispanic residents are four times as likely as others to have a shortage of physicians, regardless of community income. In a recent California study, black physicians cared for significantly more black patients and Hispanic physicians cared for significantly more Hispanic patients than did other physicians. (Komaromy, M, et al: The Role of Black and Hispanic Physicians in Providing Health Care for Underserved Populations. New England Journal of Medicine 1996; 334(20):1305-10.)

According to a survey of graduating medical students performed by the Association of American

Medical Colleges, underrepresented minorities were four times more likely to indicate that they plan to practice in areas characterized as “socioeconomically deprived” than other graduates. Additionally, the respondents indicated that underrepresented minorities were more likely to enter generalist specialties. (AAMC: Specialty Choice, Intended Practice Location, and Ethnic Identity: Career Plans of the 1996 Graduating Medical School Class. AAMC Fact Sheets 1997; 1(11):1.)

**Performance:**

This program was not implemented until Fiscal Year 2000 and no performance data will be available until FY 2002. Each hospital will be asked to submit on an annual application the percentage of and race/ethnicity of residents in each program.

**Goal-level data issues:**

Data on the race and ethnicity of trainees is not routinely collected by training programs or hospitals. The information will be requested on an annual application submitted by each participating hospital.

**Goals IV.A.1 Monitor Trends in the Financial Status of Participating Hospitals**

**IV.A.2 Monitor the Proportion of Uncompensated Care Patients**

**IV.A.3 Monitor the proportion of Medicaid Patients**

**Context:**

Children’s hospitals by several measures have poorer financial status than most other teaching hospitals. In 1995, 58% if these hospitals had negative operating margins. Compounding this have been the major changes in the health care system. Factors such as increased pressure at all levels of health care, the expansion of managed care, and the increased effort to constrain health care costs may put health facilities that train physicians at a competitive disadvantage in the new marketplace. In the competitive marketplace, payers of health care services have few, if any, incentives to pay higher costs to sites that train health professionals.

**Performance:**

This program was not implemented until Fiscal Year 2000 and no performance data will be available until FY 2002. Each hospital will be asked to submit on an annual application the: 1) Total and operating margins, 2) Percentage of patients served enrolled in Medicaid and 3) Percentage of uninsured patients and uncompensated care.

**Goal-level data issues:**

Most children’s hospitals collect such information for their own purposes. Some may be reluctant to

share detailed financial information for various reasons including privacy.

#### **Goal IV.B.1. Improve or Maintain the Percentage of Residents Passing their Board Exams**

##### **Context:**

Numerous studies have utilized measures of board pass rate as an indicator of quality of training, knowledge and skills.

##### **Performance:**

This program was not implemented until Fiscal Year 2000 and no performance data will be available until FY 2002. Each hospital will be asked to submit on an annual application the percentage of graduated residents passing their board exams on the first attempt.

##### **Goal-level data issues:**

The timing of the exams will impact when the information can be made available for the purposes of the CHGME Program. The children's hospitals will not be able to readily collect board scores and pass rates for resident trainees rotating in from programs sponsored by other hospitals.

## **FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report**

### **2.20 Program Title: Health Education Assistance Loans (HEAL)**

<b>Performance Goals</b>	<b>Targets</b>	<b>Actual Performance</b>	<b>Reference</b>
<b>IV. IMPROVE PUBLIC HEALTH AND HEALTH CARE SYSTEMS</b> <b>B. Promote Education and Training of the Public Health and Health Care Workforce</b> 1. Conduct an orderly phase-out of the outstanding loan portfolio.	FY 01: \$3,500,000,000 FY 00: \$3,600,000,000 FY 99: \$3,700,000,000 FY 98: \$3,800,000,000	FY 01: FY 00: FY 99: \$3,700,000,000 FY 98: \$3,800,000,000	B277
2. Reduce the amount of HEAL claims to be paid from the liquidating account. (Amount paid)	FY 01: \$10,000,000 FY 00: \$35,000,000 FY 99: \$38,000,000 FY 98: \$50,000,000	FY 01: FY 00: FY 99: \$27,087,241 FY 98: \$38,295,256	B277
Total Funding: HEAL (\$ in 000's)	FY 01: \$13,679 FY 00: 18,687 FY 99: 40,679 FY 98: 34,261		

#### **2.20.1 Program Description, Context and Summary of Performance**

##### **Context:**

The HEAL program's authority to make new loans expired in FY 1999. The program was created to provide last dollar financial support to students of diverse socio-economic backgrounds attending schools of allopathic medicine, osteopathic medicine, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health, health administration, clinical psychology, and chiropractic. Since the program's inception, \$4,000,000,000 has helped 156,000 students pay for their health professions education. The program continues to have an outstanding portfolio of more than \$3,700,000,000 which will not be fully repaid until the year 2031.

Although authority to make new HEAL loans expired in FY 1999, the outstanding loan portfolio of more than \$3.7 billion will require management and oversight until 2031, when the last loan is fully repaid. HEAL program activities include developing default reduction and prevention efforts designed to help borrowers manage their indebtedness and remain in practice, and partnering with lenders and holders to assure that HEAL claims payments continue to decline. HEAL Refinancing is an ongoing initiative that provides borrowers with significant savings in loan payments and reduces both the total Federal liability and the actual default payments made by the Federal Government. As part of its efforts to induce repayment from defaulters and deter other borrowers from defaulting, the HEAL program maintains an Internet listing of HEAL defaulters who are excluded from the Medicare program. The HEAL portfolio is also being analyzed to determine the feasibility of developing other innovative approaches for preventing defaults and rehabilitating defaulted borrowers, especially among underrepresented minority (URM) borrowers, in order to keep URM health professionals in practice and improve access to care.

The HEAL program works closely with lenders and holders to analyze loan activity and assure that loan collection procedures are structured in a manner that minimizes defaults. In addition, as part of its default prevention and reduction efforts, the HEAL program provides technical assistance to States that are interested in suspending professional licenses of HEAL defaulters. The HEAL program also coordinates with the Office of Inspector General regarding the publication of HEAL defaulters who are excluded from the Medicare program.

#### **Program-wide performance:**

The HEAL program remains committed to proper management and oversight of the \$3,700,000,000 outstanding loan portfolio. This includes providing the 101,063 HEAL borrowers who have not yet fully repaid their loans with appropriate assistance to facilitate the repayment of their loans, working with borrowers, lenders, and loan holders to minimize defaults, and aggressively pursuing HEAL defaulters.

#### **2.20.2 Goal-by-Goal Presentation of Performance**

##### **Goal IV.B.1: Conduct an orderly phase-out of the loan insurance authority.**

##### **Context:**

Although the authority to make new HEAL loans expired in FY 1999, the outstanding loan portfolio of more than \$3,700,000,000 will require management and oversight until 2031, when the last loan is fully repaid.

**Performance:**

Because the authority to make HEAL loans expired in FY99, the performance goals have been changed from a measure of awards made to repayment of loans and phase-out of the outstanding loan portfolio. The baseline level represents original loan amounts and accrued interest for the HEAL outstanding loan portfolio. Target estimates reflect the results of HEAL default reduction and prevention efforts and the repayment of HEAL loans.

**Goal IV.B.2 Reduce the amount of HEAL claims to be paid from the liquidating account.****Context for the goal:**

HEAL program initiatives include a strong emphasis on innovative activities including loan refinancing designed to reduce the amount of HEAL claims to be paid from the liquidating account. This will minimize the Federal liability associated with the HEAL program.

**Performance:**

The baseline and targets were established using the HEAL claims projection model that has been developed by HEAL program officials in conjunction with the Office of Management and Budget. This model considers numerous variables that affect HEAL claims payment amounts. These levels have been established using the HEAL claims projection model, which is based on historical HEAL trends. The FY 99 Actual Performance for HEAL claim payed was significantly lower than the FY 99 Target due to tight management control.

## FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY1999 Performance Report

### 2.21 Program Title: National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB)

Performance Goals	Targets	Actual Performance	Ref.
<b>III. ASSURE QUALITY OF CARE</b> <b>B. Assure Effectiveness of Care</b> 1. Increase the use of the NPDB and HIPDB for decision-making by queriers.	<u>NPDB</u> FY 01: 4,300,000 q* 14,350 d* FY 00: 4,000,000 q* 13,350 d* FY 99: 3,200,000 q* 10,400 d*  <u>HIPDB</u> FY 01: 1,800,000 q* 1,800 d* FY 00: 700,000 q* 700 d*  * q = Queries. <i>FY 00 and FY 01 NPDB estimates include increased querying resulting from projected adoption of "Section 5"</i>  * d = Decisions affected by responses	<u>NPDB</u> FY 01:  FY 00:  FY 99: 3,235,621 q* 10,800 d* FY 98: 3,164,119 q* 10,000 d*  <u>HIPDB</u> FY 01:  FY 00:  * q = Queries.  * d = Decisions affected by responses	B187

Performance Goals	Targets	Actual Performance	Ref.
2. Increase the number of databases the NPDB and HIPDB use as information sources to improve the quality of information in the NPDB and HIPDB.	FY 01: 4 data bases FY 00: 3 data bases FY 99: 2 data bases	FY 01: FY 00: FY 99: 2 FY 98: 1	B187
<b>Total Funding: National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank</b>	FY 01: \$17,200,000 NPDB uf* \$ 4,317,000 HIPDB uf* <u>\$ 2,443,000</u> HIPDB app* \$23,960,000 FY 00: \$16,000,000 NPDB \$ 3,238,000 HIPDB uf* <u>\$ 916,000</u> HIPDB appr* \$20,154,000 FY 99: \$15,636,000 NPDB uf* <u>\$ 4,433,000</u> HIPDB appr* \$20,069,000 FY 98: \$12,051,527 NPDB uf* <u>\$ 1,000,000</u> HIPDB appr* \$13,051,527 *appr = HCFAC Account appropriated funds; FY 00 is President's budget, FY 01 is an estimate; actual funding to be based on allocation by the Secretary of HHS and the Attorney General based on FY 01 appropriation. *uf = user fees		B187

### **2.21.1 Program Description, Context and Summary of Performance**

#### **Context:**

Prior to establishment of the National Practitioner Data Bank (NPDB) a healthcare practitioner could easily escape the scrutiny of medical oversight organizations simply by moving to another state. The NPDB provides a national data repository which can be accessed by licensing, privileging, and credentialing authorities prior to granting licensure or extending clinical privileges. The NPDB tracks all significant adverse professional actions against physicians and dentists as well as malpractice settlements and judgments against all licensed health care professionals.

HRSA is developing and operating the Healthcare Integrity and Protection Data Bank (HIPDB) for the OIG and the Department of Justice to implement a requirement of the Healthcare Insurance Portability and Accountability Act of 1996. The HIPDB is operated in conjunction with the NPDB. It augments information available in the NPDB and will assist the NPDB in implementing reporting of licensure and clinical privileging information for practitioners other than physicians and dentists when "Section 5" regulations are adopted. The HIPDB opened for reporting in November 1999 and will open for queries in early 2000.

Medical malpractice insurance companies, State licensing boards, health care entities such as hospitals, HMOs, group practices and professional societies are required to report information to the NPDB on paid medical malpractice judgments and settlements, sanctions, certain professional review actions, and adverse membership actions involving licensed practitioners. The NPDB also receives reports of practitioner exclusions from the Medicare and Medicaid program. Hospitals are required to query the NPDB and currently are responsible for about 1/3 of all queries to the NPDB. State licensure agencies, and health care entities and professional societies which meet certain requirements are permitted to query the NPDB. These voluntary queriers submit about 2/3 of all queries to the NPDB. The NPDB is funded through user fees (currently a base fee of \$4.00 per query) rather than appropriated funds.

Health plans and federal and state programs and officials (including licensing agencies, certification agencies, criminal prosecutors, government attorneys participating in civil cases, and agencies taking program exclusion actions) are required to report to the HIPDB all final adverse actions (such as revocations, suspensions, exclusions, criminal convictions and civil judgments) against health care providers, suppliers, and practitioners. Federal and State agencies and health plans are permitted to query the HIPDB. Although appropriated funds were used to develop the HIPDB, once it is fully operational, it will be funded through user fees (expected to be a base fee of \$4.00 per query) rather than appropriated funds.

The services provided by the NPDB operation will be augmented by the opening of the HIPDB during

FY 00. The NPDB and HIPDB programs will be operated so that entities required to report to both data banks need only file one report and queriers eligible to obtain information from both data banks need only query once. In addition to information required to be reported by law to the NPDB, the Department has agreements for voluntary reporting and querying by the Department of Defense, the Department of Veterans Affairs, and the Department of Justice, Drug Enforcement Administration. Medicare and Medicaid exclusions also are reported by HCFA and the OIG.

**Program-wide performance:**

As of September 30, 1999, the NPDB contained 221,635 reports on 142,432 practitioners. Approximately 76% of these reports concerned malpractice payments; approximately 15 percent concerned licensure actions. Slightly more than 5 percent were Medicare/Medicaid exclusions. Most of the remainder were clinical privileges actions. Almost 72% of the practitioners with reports were physicians. About 15% were dentists. Although 71% of practitioners with reports in the NPDB have only one report, the NPDB has an average of 1.56 reports for each practitioner with reports. During FY 99, the NPDB processed 3,235,621 queries from more than 9,600 registered entities. Querying entities received 399,943 responses from the NPDB which contained reports on the queried practitioners. They also received 2,835,318 responses which confirmed that the named practitioner had no malpractice payments, adverse actions, or exclusions since September 1, 1990. During FY 99 the NPDB also provided responses to 41,925 self-queries from practitioners. Of these responses, 3,753 contained reports; the remainder confirmed that the practitioner had no reports on file in the NPDB. The HIPDB had not yet begun receiving queries during FY 99.

**Program-level data issues:**

The NPDB has conducted user surveys to obtain data concerning user satisfaction and the usefulness of the program. A series of such surveys have been conducted by a contractor and the OIG in previous years. The University of Illinois at Chicago is currently under contract to conduct a new survey on program usefulness and user satisfaction. Survey respondents will rate the NPDB on how easy it is to report to and obtain information from the NPDB, the completeness and accuracy of the information provided, how significant NPDB information is for their decision making process, and other factors. Results of this study are expected during FY 2000.

The usefulness of the NPDB program can also be inferred from the fact that entities which are not legally required to query pay more than \$8,000,000 each year to submit over 2,000,000 queries to the NPDB. These entities would not query if they did not believe the NPDB provides them with important information.

**2.21.2 Goal-by-Goal Presentation of Performance**

### **Goal III.B.1. Increase the use of the NPDB and HIPDB for decision-making by queriers.**

#### **Context:**

NPDB query response information is used by licensing boards, hospitals and other health care entities, and professional societies for licensing, privileges, and membership decisions. NPDB responses which include matched malpractice payment, adverse action, or exclusion report information have been demonstrated to affect entity decisions from 2 to 3% of the time depending on the type of entity making the query. According to OIG and consultant studies, matched responses containing NPDB reports also are valuable to querying entities when they confirm information the entities have received from other sources. NPDB “no-match” responses are likewise valuable according to survey results because these responses confirm that a practitioner has had a “clean” record since September 1, 1990. These “no-match” responses will become even more valuable as the number of years of reporting to the NPDB increases.

The NPDB serves as a central reliable source of (mostly) adverse information concerning practitioners. Practitioners may fail to include this adverse information in their licensure, privileges, or membership applications if they think that their omissions will not be discovered. Indeed, the proclivity of practitioners with less than perfect records to omit damaging information on applications was a major reason for adoption of the Health Care Quality Improvement Act of 1986, which led to the establishment of the NPDB. The existence of the NPDB makes it difficult, if not impossible, for practitioners to successfully hide damaging information from NPDB queriers. Because of the existence of the NPDB, practitioners now are more likely to disclose damaging information in their applications, presumably because they believe it would be seen as even more damaging if it appears that they were attempting to hide the information.

Eligible entities will begin querying the HIPDB during FY 00. We expect substantial numbers of queries to the HIPDB because it will contain several types of data not found in the NPDB (such as licensure actions on practitioners other than physicians and dentists and criminal convictions and civil judgments) and because it will contain information on providers and suppliers as well as practitioners. The accuracy of this expectation has been confirmed by the fact that during the HIPDB registration/NPDB re-registration process (as of the end of December 1999), almost three-quarters of all entities eligible to query both the NPDB and the HIPDB chose to query both data banks once the HIPDB opens for querying.

#### **Performance:**

Data from our entity user file supplied by the NPDB contractor indicate that the NPDB provided responses for 3,235,631 queries from entities during FY 99, this is an increase over the FY 99 Target. Queriers received 399,943 matched responses containing report information. Based on previous user surveys conducted by the OIG, an estimated 10,800 licensure, credentialing, or membership decisions

were affected by these match responses during FY 99. Using the survey information combined with current querying and response data is the most reliable available method to estimate the impact of the NPDB on decision making.

The NPDB also provided confirming information, which survey responses indicate are also generally viewed as useful by queriers an estimated 389,100 times during 1998. In addition, the NPDB confirmed that practitioner had a clean record 2,835,318 times during 1998. User surveys also indicate that this information is generally considered important by users. We expect that as the number of NPDB queries continues to slowly increase and the match rate also continues to increase, the number of decisions directly affected by NPDB information will also continue to increase as shown in the table above. It should be noted that the numbers shown above do not include any increase in querying which may result from the opening of the HIPDB or possible adoption of Section 5 regulations which would increase the number and types of reports to the NPDB.

It also should be noted that, paradoxically, the extent to which decisions are changed because of new information received from the NPDB may decrease as a greater proportion of practitioners submit complete and fully accurate applications which do not omit any negative information. This would not indicate that the NPDB is becoming less effective, but rather that its importance as a deterrent is increasing.

The OIG found that in 1992 (two years after the NPDB opened) 40% of practitioner's applications to hospitals omitted some information contained in NPDB reports. A later OIG study found that by 1994 (four years after the NPDB opened) only 28% of applications were incomplete. We anticipate that practitioners will continue to become more conscientious in completing applications as it become even more apparent that omissions will be discovered because of information from the NPDB. The current survey and future surveys will measure this impact.

No data are available to determine how many patients were saved from substandard care or improper practitioner behavior as a result of these decisions and it is unlikely that reliable data of this type could be developed.

The performance targets were increased by 21% in FY00 and 26% in FY01 to reflect the trend in actual performance. New performance targets are presented for the Health Integrity and Protection Data Bank, a program that began operation in FY00.

#### **Goal-level data issues:**

Increased querying implies increased use of NPDB and HIPDB information for decision making. We

currently measure our success in reaching the goal in terms of the number of queries submitted, which is easily measurable, and in terms of decisions affected, which is not easily measurable. Data on decisions affected, i.e., how NPDB and HIPDB data is actually used, can be obtained only from surveys of NPDB and HIPDB users. We based our counts of decisions affected on previous survey results and current information from the NPDB contractor on the number of queries and matched responses. Surveys to obtain information on user satisfaction and how NPDB query responses are used are expensive and are not conducted every year. Survey data are subject to sampling and data collection errors. We have no reason to believe, however, that there are any significant errors in the currently available survey data. As noted above, a new survey is currently being conducted. This survey will allow us to refine the decisions affected counts in the future.

NPDB query data for future years is estimated taking into account possible changes resulting from implementation of the HIPDB and “Section 5.” If “Section 5” is not implemented, these estimates will be excessive. The number of queries shown for FY 99 is the actual number of queries processed by the NPDB. “Decisions affected by responses” is an estimate based on survey data and the actual number of queries which resulted in match responses during the year.

HIPDB query and decisions affected data are based on our HIPDB business plan and budget estimates and registrations for querying the HIPDB. FY 00 estimates assume a February 1 opening date for querying. The estimated number of decisions affected by HIPDB reports is based on an assumed initial 2 percent match rate and an assumption that 5 percent of HIPDB matches will provide new information which affects decision making. These estimates will be revised as experience is gained with these programs after they become operational.

Data on the frequency with which practitioners withhold information on applications that is disclosed by the NPDB can be obtained only through surveys of NPDB users. Such surveys are expensive and are not conducted every year. Like all survey data, this type of information is subject to sampling and data collection errors. Nevertheless, the data collected on this issue by the OIG are the most reliable available. We are gathering updated information on this issue in the survey of NPDB users currently in progress.

**Goal III.B.2: Increase the number of databases which are used by the NPDB as information sources to improve the quality of information in the NPDB.**

**Context:**

The NPDB’s information can be improved by obtaining information when needed (such as to confirm license numbers, addresses, etc.) from other sources. This information is used to help resolve “partial matches,” those situations in which the NPDB cannot initially determine with reasonable certainty that the practitioner about whom information is being sought is the same practitioner on whom

information has been reported to the NPDB. Such problems arise when queries do not have complete information. These problems also may arise when practitioners have the same or similar names.

**Performance:**

The NPDB currently confirms practitioner identification and characteristics information using the AMA data base when necessary. The NPDB also obtains information from State licensure boards as necessary to identify practitioners. As practitioner information becomes increasingly available on the Internet, the NPDB plans to increase use of these sources, not only for physicians but also for other types of practitioners. When the HIPDB opens, the NPDB will also coordinate with the HIPDB for needed practitioner identification information.

**FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report**

**2.22 Program Title: National Vaccine Injury Compensation Program (VICP)**

<b>Performance Goals</b>	<b>Targets</b>	<b>Actual Performance</b>	<b>Reference</b>
<b>III. ASSURE QUALITY OF CARE</b> <b>C. Improve Customer/Patient Satisfaction</b> 1. Process payment of 90 percent of annuities within 60 calendar days of receipt of a Department of Justice (DOJ) clearance letter.	FY 01: 90% FY 00: 90% FY 99: 90%	FY 01: FY 00: FY 99: 96.0% FY 98: 92.6%	B293
2. Process payment of 90 percent of lump sum awards within 30 calendar days of receipt of a DOJ clearance letter.	FY 01: 90% FY 00: 90% FY 99: 90%	FY 01: FY 00: FY 99: 90.9% FY 98: 93.8%	B293
3. Process payment of 90 percent of attorney fees within 30 calendar days of receipt of a DOJ clearance letter.	FY 01: 90% FY 00: 90% FY 99: 90%	FY 01: FY 00: FY 99: 96.9% FY 98: 96.6%	B293
<b>Total Funding: National Vaccine Injury Compensation Program (VICP)</b> (\$ in 000's)	FY 2001: \$ 117,347 FY 2000: \$65,300 FY 1999: \$ 155,889 (\$100 million for pre- FY '89 claims) FY 1998: \$55,500	Bx: page # budget HP: Healthy People goal	

### **2.22.1 Program Description, Context and Summary of Performance**

#### **Context:**

The National Childhood Vaccine Injury Act of 1986 established the VICP to equitably and expeditiously compensate individuals, or families of individuals, who have been injured by childhood vaccines. The VICP serves to steady a previously perilous vaccine supply by substantially reducing the threat of liability for vaccine companies, physicians, and other health care professionals who administer vaccines.

An individual claiming injury from a covered vaccine files a petition for compensation with the United States Court of Federal Claims (the Court). A DHHS physician reviews the claim to determine that it meets the criteria for compensation and makes a recommendation to the Court. If the Special Master, appointed by the Chief Judge of the Court, is satisfied that an injury was caused by a covered vaccine, the VICP makes the appropriate payments based on the decision rendered by the Court. Awards are paid out of a trust fund financed through collection of an excise tax levied on each dose of covered vaccine administered.

The VICP is administered in close coordination with the U.S. Court of Federal Claims and the Department of Justice, whose attorneys represent the VICP during the proceedings before the Special Master. The nine member Advisory Commission on Childhood Vaccines meets quarterly to advise the Secretary on program structure and implementation.

#### **Program-wide performance:**

The VICP has been very effective. Since it was implemented in 1986 the number of lawsuits alleging DTP vaccine-caused injury dropped from 255 to just 4 in 1997 while filings for investigational new drug exemptions for non-AIDS vaccines rose from 17 in 1987 to 49 in 1997.

#### **Program-level data issues:**

The VICP maintains a highly controlled internal data system, which contains detailed case-specific data values for the over 5,000 claims filed. This control data system includes legal, epidemiological, medical, diagnostic, and payment information, and is used for often highly complex cross-linking data analysis. Information contained in these tables have been reviewed and validated by the Office of Inspector General (OIG), the General Accounting Office (GAO), the Congressional Budget Office, and Agency and Departmental independent actuarial contractors.

Additionally, the OIG conducted a comprehensive Program study in 1992, and released a very favorable report on the management, operations, and success of the VICP. This study was eventually submitted to Congress to satisfy a statutory reporting requirement. Currently, the GAO is conducting a program review at the request of Senator Jeffords. The GAO has indicated that the results of the

report will be favorable. It is scheduled to be released on January 22, 2000. Further, the GAO has scheduled a follow-on review of specific financial components of the program pursuant to a request by the House Ways and Means Committee and the Senate Finance Committee.

#### **2.22.2 Goal-by-Goal Presentation of Performance**

##### **Goal III.C.1: Process payment of 90 percent of annuities within 60 calendar days of receipt of a Department of Justice (DOJ) clearance letter.**

###### **Context:**

Timely, efficient resolution of claims is one of the primary objectives of the VICP and prompt payment of annuities contributes materially to its success.

###### **Performance:**

Performance standards were conceptualized, developed, and implemented following careful consideration by program officials, and in partnership with the Department of Justice, Office of the General Counsel, VICP Petitioners' Attorneys, and the Advisory Commission on Childhood Vaccines. Standards were, in part, based on requirements of the Prompt Payment Act and customary business practices in the private sector, with emphasis made on ensuring strict standards to satisfy the often urgent needs of the beneficiaries of the program. Additionally, the VICP negotiates and purchases annuity contracts, and requires the monitoring of market conditions, necessitating a payment system that mirrors (and exceeds) the private sector. Claims are paid in an exceptionally timely, efficient manner. In FY 1999, 96.0 percent of annuities were processed within 60 calendar days. This exceeds the target by 6.0 percentage points.

##### **Goal III.C.2: Process payment of 90 percent of lump sum awards within 30 calendar days of receipt of a DOJ clearance letter.**

###### **Context:**

Timely, efficient resolution of claims is one of the primary objectives of the VICP and prompt payment of lump sums contributes materially to its success.

###### **Performance:**

See the performance statement for III.C.1.

Lump sum awards are paid in an exceptionally timely, efficient manner. In FY 1999, 90.9 percent (exceeding the target of 90 percent) of lump sum awards were processed within 30 days.

**Goal III.C.3: Process payment of 90 percent of attorney fees within 30 calendar days of receipt of a DOJ clearance letter.**

**Context for the goal:**

Timely, efficient resolution of claims is one of the primary objectives of the VICP and prompt payment of attorney fees contributes materially to program success.

**Performance:**

See the performance statement for III.C.1. Payments for attorney's fees were made in a very timely, efficient manner. In FY 1999, 96.9 percent of payments for attorney's fees were processed within 30 days, compared with a target of 90 percent.

**FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report**

**2.23 Program Title: Ricky Ray Hemophilia Relief Fund Program (RRHRP)**

<b>Performance Goals</b>	<b>Targets</b>	<b>Actual Performance</b>	<b>Reference</b>
<b>III. ASSURE QUALITY OF CARE</b> <b>C. Improve Customer/Patient Satisfaction</b> 1. Issue Notice of Intent Case Number letter to each individual that files a Notice of Intent to File a Petition with RRHRP.	FY 01: 100% FY 00: 100% FY 99: 65%	FY 01: (11/01) FY 00: (11/00) FY 99: 70%	B267
2. Complete the determination whether a petition meets the requirements of the Act no later than 120 days after the date a completed petition is filed with RRHRP. (Dependent upon completion of program regulations)	FY 01: 100% FY 00: 100% FY 99: NA	FY 01: (11/01) FY 00: (11/00) FY 99: NA	B267
3. Subject to availability of sufficient amounts in the Fund, process payment of 90 percent of petitioner payment awards within 30 calendar days of approval of a completed petition. (Dependent upon completion of program regulations)	FY 01: 90% FY 00: 90% FY 99: NA	FY 01: (11/01) FY 00: (11/00) FY 99: NA	B267
<b>Total Funding: Ricky Ray Hemophilia Relief Fund Act of 1998</b> (\$ in 000's)	FY 2001: \$100,000 FY 2000: \$ 75,000 FY 1999: \$ 0	B x: page # budget HP: Healthy People goal	

### **2.23.1 Program Description, Context and Summary of Performance**

#### **Context:**

The Ricky Ray Hemophilia Relief Fund Act of 1998 (the “Act”) was signed on November 12, 1998 to provide for “compassionate payments” of \$100,000 by the Secretary to certain individuals who acquired HIV infection from treatment with antihemophilic factor during the period July 1, 1982 through December 31, 1987. Section 101 of the Act establishes in the Treasury of the United States a trust fund known as the Ricky Ray Hemophilia Relief Fund. The Act authorizes appropriations to the Fund of \$750,000,000. The FY 2000 Labor/HHS/Education appropriation provided funding to initiate this program.

On March 24, 1999, the Secretary established as a first procedure under the Act the opportunity for individuals to file Notices of Intent to File Petitions, which may lead to later filings of full petitions and determinations on those petitions when appropriate.

HRSA is currently developing regulations to implement the Act and to determine the policies and procedures for submitting a full petition and for prioritizing payments, as required. Subsequent to the issuance of these regulations, individuals may submit petitions for compassionate payments from the Fund. HRSA will review each petition and supporting medical and legal documentation and make recommendations regarding the petitions for compassionate payment. Subject to the availability of appropriated funds, HRSA will process award payments on approved petitions for compassionate payment.

The program is administered in close coordination with HRSA’s Office of General Counsel and officials within HRSA’s Bureau of Health Professionals. The program has also consulted with national hemophilia advocacy groups with regard to the programs policies and procedures. The Ricky Ray Program Office has already received more than 5,700 Notices of Intent to File a Petition. The Ricky Ray Program Office has responded to each Notice of Intent with an acknowledgment letter reflecting a case number assigned to the filing. The name, address and phone number of each petitioner, together with the name address and phone number of the petitioner’s attorney of record, or other representative for the petition, if any, has been added to a database. The Ricky Ray Program Office will advise those who submitted Notices of Intent of the content, format, and deadlines for future submissions related to the petition.

On December 10, 1999, HRSA published a notice of a proposal to add a new system of records, in accordance with the Privacy Act of 1974. The new system is titled “Ricky Ray Hemophilia Relief Fund Act of 1998, HHS/HRSA/BHPr. HRSA has also established the Ricky Ray Hemophilia Relief Fund in the Department of the Treasury and organized accounting and auditing procedures for payments of awards.

The Ricky Ray Program Office , in conjunction with departmental contractors, will maintain a highly controlled data system, which will contain detailed case-specific data for the petitions filed under the Program. This control data system will include legal, medical, diagnostic, and payment information, to be used in the review process for determining whether a petition meets the requirements of the Act.

### **2.23.2 Goal-by-Goal Presentation of Performance**

#### **Goal III.C.1: Issue Notice of Intent Case Number letter to each individual that files a Notice of Intent to File a Petition with RRHRP.**

##### **Context:**

The Notice of Intent to File a Petition system was established by the Secretary as the initial procedure for individuals who may wish to file a full petition. Subsequent to the issuance of Program regulations, the RRHRP will advise those who submit Notices of Intent of the content, format and deadlines for filing full petitions under the Act.

##### **Performance:**

Performance standards were conceptualized, developed, and implemented following careful consideration by Program officials, in concert with the Office of the General Counsel (OGC). Standards were, in part, based on ensuring strict standards to satisfy the often urgent needs of the beneficiaries of this Program. As of January 14, 2000, the RRHRP has issued a Case Number letter to 100% of all individuals that have filed a Notice of Intent to File a Petition with the RRHRP.

#### **Goal III.C.2: Complete the determination whether a petition meets the requirements of the Act no later than 120 days after the date a completed petition is filed with the RRHRP.**

##### **Context:**

HRSA is currently developing regulations to determine the content and format of a full petition, the policies and procedures for submitting a full petition and the method for prioritizing payments, as required. Subsequent to the issuance of these regulations HRSA will call for petitions to be filed with the RRHRP. Timely, efficient resolution of claims is one of the primary objectives of the RRHRP. (Dependent upon completion of Program regulations).

##### **Performance:**

Performance standards are set forth in Section 103 (d) of the Act. The 120 day review period described in Section 103 (d) will begin upon receipt of a full petition containing all information as specified in the Program regulations.

**Goal III.C.3: Subject to availability of sufficient amounts in the Fund, process payment of 90 percent of petitioner payment awards within 30 calendar days of approval of a completed petition.**

**Context:**

HRSA is currently developing regulations to determine the content and format of a full petition, the policies and procedures for submitting a full petition and the method for prioritizing payments, as required. Subsequent to the issuance of these regulations HRSA will call for petitions to be filed with the RRHRP. Timely, efficient resolution of claims is one of the primary objectives of the RRHRP and prompt payment of petitioner payment awards contributes materially to its success. (Dependent upon completion of Program regulations)

**Performance:**

The target is set to process payment of 90 percent of payment awards within 30 days of approval of a completed petition. Performance standards were conceptualized, developed, and implemented following careful consideration by Program officials, in concert with OGC. Standards were, in part, based on requirements of the Prompt Payment Act and customary business practices in the private sector, with emphasis made on ensuring strict standards to satisfy the often urgent needs of the beneficiaries of this Program.

## **OFFICE OF SPECIAL PROGRAMS**

### **FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY1999 Performance Report**

The Office of Special Programs (OSP) in HRSA is responsible for two program activities in the Division of Transplantation involving the transplantation of organs, tissues, and bone marrow to treat those with life threatening diseases.

The total number of organ transplants increased 60% between 1988 and 1998, but the number of transplant candidates is rising faster than the number of donors. 1998 data show 5,799 donors, up from 5,477 the year before. This is not enough of an increase to keep pace with the need for organs. 1999 data show 66,983 registrants waiting for organs, representing a 10% increase from 1998, and the gap between supply and demand for organs continued to widen. Between 1995 and 1997, the median waiting times for all organs increased. There were 4,327 reported deaths on the waiting list in 1997, up from 1,484 deaths reported in 1988. Furthermore, the number of people on the waiting list is increasing much faster than the number of transplants. Every year the need for organ donation is greater.

The HRSA OSP transplantation programs are authorized by the National Organ Transplant Act of 1984, as amended; and the National Bone Marrow Registry Reauthorization Act of 1998. Taken together, these programs reflect the HRSA/OSP's major strategic organ/tissue and marrow transplantation goals of increasing the numbers of organ donors nationally, increasing the number of minority organ donors nationally, increasing the number of unrelated patients receiving marrow transplants nationally, increasing the number of unrelated marrow donors nationally, increasing the number of minority patients receiving marrow transplants nationally, and increasing the number of unrelated minority donors nationally.

Programs included in this section are:

- 2.24 Organ Procurement and Transplantation
- 2.25 National Bone Marrow Donor Program

**FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY1999 Performance Report**

**2.24 Program Title: Organ Procurement and Transplantation**

<b>Performance Goals</b>	<b>Targets</b>	<b>Actual Performance</b>	<b>Reference</b>
<b>I. ELIMINATE BARRIERS TO CARE</b> <b>C. Focus on Target Population</b> 1. Increase by 20% over two years the number of organ donors nationally from implementation of the final HCFA Rule on Conditions of Participation of Hospitals. (Sept. 98)	FY 01: 7,248 donors FY 00: 6,589 FY 99: 5,990	FY 01: FY 00: FY 99: (5/00) FY 98: 5,799 FY 97: 5,477 donors	B225
<b>II. ELIMINATE HEALTH DISPARITIES</b> <b>B. Increase Utilization for Underserved Populations</b> 1. Increase by 20% over two years the number of minority organ donors nationally from implementation of the final HCFA Rule on Conditions of Participation of Hospitals.	FY 01: 1,802 donors FY 00: 1,638 FY 99: 1,489	FY 01: FY 00: FY 99: (5/00) FY 98: 1,378 FY 97: 1,342 donors	B225
<b>Total Funding: Organ Procurement and Transplantation</b> (\$ in 000's)	FY 2001: \$15,000 FY 2000: \$10,000 FY 1999: \$ 9,997 FY 1998: \$ 2,778	B x: page # budget HP: Healthy People goal	

**2.24.1 Program Description, Context and Summary of Performance**

The HRSA/Office of Special Program (OSP) organ procurement and transplantation programs are

authorized by the National Organ Transplant Act of 1984, as amended. The Division of Transplantation's (DoT) principal responsibilities include the management of the Organ Procurement and Transplantation Network (OPTN), Scientific Registry of Transplant Recipients (SRTR), National Marrow Donor Program (NMDP) contracts, public and professional education, technical assistance to organ procurement organizations (OPO's), administration of the "Model Interventions to Increase Organ and Tissue Donation" grant program. For organ procurement and transplantation data, OSP/DoT is dependent upon the United Network for Organ Sharing (UNOS) which hold the Federal OPTN and SRTR contracts. UNOS continually updates this data and publishes an annual report of transplantation activities. The 1999 Annual report contains data from 1989 to 1998 inclusive; it should be noted that 1999 data are not available.

DoT's activities support the National Organ and Tissue Donation Initiative (the National Initiative), launched in December 1997 by Vice President Al Gore and HHS Secretary Donna Shalala. The intent of the National Initiative is to increase the number of organ donors by 20% over two years beginning with the implementation of HCFA's Hospital Conditions of Participation (COP) for Organ, Tissue, and Eye Donation in August 1998. Working with HHS, HRSA/OSP/DoT is partnering with an array of organizations across the U.S., building on more than a decade of experience gained from government, private, and volunteer efforts. DoT's goals and performance measures reflect the three major goals of the National Initiative.

- \*Increasing consent to donation
- \*Ensuring that families are asked about donation
- \*Learning more about what works to increase donation

The first goal can be viewed from two perspectives: 1) family consent at the time of request for the donation of a loved one's organs in the hospital setting; and 2) individual declaration of intent to donate via an advance directive, e.g., donor card or driver's license. DoT is addressing family consent through increasing awareness about organ and tissue donation, assessing the potential donor family's hospital experience, promoting family discussion about donation, and working with HCFA on implementation of the COP's requirement for training of designated requestors. Increasing individual declaration of intent is addressed through DoT programs encouraging people to sign donor cards or have donor indicators on driver's licenses, and critically, to follow these actions with a family discussion about the decision. A Gallup study has indicated that nearly all Americans would consent to donate their loved ones' organs if they knew beforehand that their loved ones wanted to donate. Programs in both family consent and individual intent are targeted to a variety of age and ethnic groups.

The second goal is intended to assure that families of all potential donors are given the opportunity to consent to donation. This is especially important because it has been suggested that improved trauma

care, seat belt and helmet law enforcement, and technical advancements in critical care medicine has contributed to the number of medically suitable potential donors holding constant, or even decreasing. A constant or decreasing number of suitable potential donors is a serious challenge to the achievement of a 20% increase in the number of donors in two years. Thus, it is imperative that all possible families are asked about donation. The COP contains a provision that all hospital deaths and imminent deaths are to be reported to the OPO serving the hospital. In this way, all potential donors can be identified and request procedures can be initiated. In addition, the actual donor pool may be increased through the adoption of expanded donor criteria. DoT supports public and professional education activities in these areas.

## **2. 24.2 Goal-by-Goal Presentation of Performance**

**Goal I.C.1: Increase by 20% over two years the number of organ donors nationally from implementation of the final HCFA Rule on Conditions of Participation of Hospitals (September, 1998).**

### **Context:**

This goal is consistent with the Department's National Initiative (described in 2.28.1 above). It is believed that implementation of the HCFA Rule will enable the goal to be met. Prior to the publication of the Rule, donation had been flat for several years. In the first partial year after publication, donation increased appreciably.

Indicator:

Number and percent change of organ donors nationally from implementation of the final HCFA Rule on Conditions of Participation of Hospitals.

### **Performance:**

FY 1998 data show 5,799 donors, up from 5,477 the year before. This is an increase of 5.9%. During the same time period, the number of people waiting increased 13.5% from 53,505 to 60,712. From the end of 1998 until the end of 1999, the number of people waiting for organs increased from 60,712 to 66,983, or 10.3%. Although the rate of increase in the number of people waiting was slower in 1999, it continues to outpace the increase in cadaveric donation.

**Goal II.B.1: Increase by 20% over two years the number of minority organ donors nationally from implementation of the final HCFA Rule on Conditions of Participation of Hospitals.**

### **Context:**

This goal is also consistent with the Department's National Initiative described above. Just as implementation of the HCFA Rule is expected to lead to a 20% increase in overall donation, it is expected to lead to a 20% increase in minority donation. Based on most recent data for 1998, it

appears that getting to 20% will be a greater challenge with minority donation than for overall donation. Expanded public information and education efforts may be required.

Indicator: Number and percent change of minority organ donors nationally from the effective date of the final HCFA Rule on Conditions of Participation of Hospitals.

**Performance:**

Trend Data:

1997:

651 Black donors

552 Hispanic donors

107 Asian donors

31 Other donors

1 Unknown donors in 1998 = 1,342 minority donors

1998:

654 Black donors

559 Hispanic donors

98 Asian donors

31 Other donors

1 Unknown donors in 1998 = 1,378 minority donors

FY 1999 Goal: 1,489 minority organ donors

FY 2000 Goal: 1,638 minority organ donors

FY 2001 Goal: 1,802 minority organ donors nationally

**Data Collection and Validation**

Data for performance goals were obtained from the following sources:

National Organ and Tissue Donation Initiative *Fact Sheet*

*Medicine and Health*, April 27, 1998, p. 3

HHS News Press Release, April 16, 1999

*1998 Annual Report* by UNOS, funded in part by HHS, pp.1, 2,15, and 32

**FY 2001 Performance Plan, Revised FY 2000 Final Plan and FY 1999 Performance Report**

**2.25 Program Title: National Bone Marrow Donor Program**

Performance Goals	Targets	Actual Performance	Reference
<b>I. ELIMINATE BARRIERS TO CARE</b> <b>C. Focus on Target Population</b> 1. Increase by 7.5% the number of unrelated bone marrow donors (national registry of potential donors) over previous year totals.	FY 01: 4.35M donors FY 00: 4.04M FY 99: 2.84M	FY 01: FY 00: FY 99: 3.76 FY 98: 3.36 FY 96: 2.58 M donors	B227
<b>II. ELIMINATE HEALTH DISPARITIES</b> <b>B. Increase Utilization for Underserved Populations</b> 1. Increase by 10% the number of unrelated minority bone marrow donors (national registry of potential donors) over previous year totals.	FY 01: 1,100,000 donors FY 00: 1,000,000 FY 99: 220,000* *New donors. Total minority donors estimated at 900,000.	FY 01: FY 00: FY 99: (5/00) FY 98: 800,000 FY 96: 526,000 donors	B227
<b>Total Funding: National Bone Marrow Donor Program</b> (\$ in 000's)	FY 2001: \$ 17,959 FY 2000: \$ 18,000 FY 1999: \$ 17,994 FY 1998: \$ 15,270	B x: page # budget HP: Healthy People goal	

**2.25. 1 Program Description, Context and Summary of Performance**

**Context:**

The National Marrow Donor Program operates the national registry of volunteers willing to donate bone marrow to people with leukemia and other life threatening blood-based diseases who need a bone marrow transplant, but lack a relative with a matching tissue type. Through the program,

volunteer donors are recruited and tissue typed, the national registry of potential donors is maintained, computerized searches of the registry are conducted for patients, marrow is collected and provided for transplants maintained. The program provides information and case management for patients and their families, public and professional educational materials, and resources for transplant centers to conduct successful searches for unrelated matched donors. Research to improve the number and effectiveness of stem cell transplants using unrelated donors is conducted and supported by the program.

### **Program-level Performance:**

Unrelated transplants are now performed using umbilical cord blood obtained at birth and peripheral blood stem cells derived through the process of apheresis, as well as bone marrow. There have also been many improvements in HLA-typing, moving toward more accurate DNA-based methods, and in procedures to reduce Graft-versus-Host disease (VHD). Currently, the NMDP Registry is made up of more than 3.7 million potential volunteer donors and the program has facilitated more than 9,000 transplants (over 1,300 in 1999). The NMDP's primary goal continues to be to provide the best possible source of hematopoietic stem cells from unrelated donors for patients who could not otherwise receive a transplant. Many diseases may be potentially cured with stem cell transplantation. As stem cell transplantation is more widely used as a therapy, and as evidence of its success as a therapy becomes more prevalent, it will likely be developed as an effective treatment for additional conditions.

### **2.25.2 Goal-by-Goal Presentation of Performance**

**Goal I.C.1: Increase by 7.5% the number of unrelated bone marrow donors (national registry of potential donors) over previous year totals.**

#### **Context:**

The mission of the NMDP is to provide stem cells for transplants from compatible unrelated donors for patients from all racial and ethnic groups. In order for transplantation to succeed potential donors must match patients searching for a compatible donor. The likelihood of a potential donor matching a searching patient increases as the number of potential donors available on the Registry increases.

Indicator: Number and percent change of unrelated bone marrow donors (on the national registry).

#### **Performance:**

The number of potential donors has been increasing by at least 8% during the last three years but this increase is expected to level off as costs of registering potential donors increase.

Baseline: 2.58 million bone marrow donors in 1996

FY 99: 2.84

FY 2000 Goal: 4.04 million\* (This is revised from the original target of 3.12 million donors based on the improved data base and a 7.5% increase).

FY 2001 Goal: 4.35 million bone marrow donors.

**\* Revisions:**

Baseline is based on actual number of potential bone marrow donors on the national registry at the end of FY 96, rather than the end of calendar year 1996.

The FY 2000 goal is based on actual FY 99 performance of 3.76 million. This reflects the availability of more complete data on potential donor recruitment in recent years.

**Goal II.B.1: Increase by 10% the number of unrelated minority bone marrow donors (national registry of potential donors) over previous year totals.**

**Context:**

The mission of the NMDP is to provide stem cells for transplants from compatible unrelated donors for patients from all racial and ethnic groups. In order for transplantation to succeed potential donors must match patients searching for a compatible donor. The likelihood of a potential donor matching a searching patient increases as the number of potential donors of the same race/ethnicity on the registry increases. Statutory language notes that a primary function of the registry is to “increase the representation of individuals from racial and ethnic minority groups in the pool of potential donors for the registry in order to enable an individual in a minority group, to the extent practicable, to have a comparable chance of finding a suitable unrelated donor as would an individual not in a minority group”.

Indicator: Number and percent change of unrelated minority bone marrow donors (national registry of potential donors) nationally.

**Performance:**

The number of potential donors has been increasing by at least 10% during the last three years, in part because of targeted recruitment efforts.

Baseline: 526,000 minority bone marrow donors on registry at end of 1996; increasing to 800,000 by end of FY 98.

FY 98. A cumulative total of 1,290 minority patients received stem cell transplants facilitated by the

national registry in FY 99, an increase of 21.13% over FY 98. The number of transplants is directly related to the ability to find a compatible donor who is available for transplant.

FY 99: 220,000 was the figure used to represent the minority bone marrow donors recruited to the registry in FY 99 instead of the total (900,000) potential minority bone marrow donors on registry at end of FY 99. The way the target was reported in FY 99 has been changed and is now being reported a different way for FY 2000 and FY 2001. This gives a better measurement of the performance goal.

FY 2000 Goal: 1.0 million\* potential minority bone marrow donors on registry. 100,000 projected to be recruited in FY 2000.

FY 2001 Goal: 1.1 million potential minority bone marrow donors on registry.

\* Revisions:

FY 2000 target is based on actual FY 99 performance. For recruitment of minority donors of unrelated bone marrow, the baseline and FY 2000 target have been substantially revised to reflect more complete data now available on potential donor recruitment in recent years which shows the effect of targeting minority donors.

#### **Data Issues:**

Data for performance goals were obtained from the National Marrow Donor Program. Data are provided to HRSA/Division of Transplantation monthly. The data are collected on a computerized system that contains information concerning potential donors, tissue typing results, potential recipients searching for a compatible donor, and transplant outcomes. These data are revised continuously as updated information becomes available. HRSA/DoT reviews reports and statistics as do the Board of Directors of the NMDP and the various NMDP committees.

## **RURAL HEALTH**

### **FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY1999 Performance Report**

The charge to the Office of Rural Health Policy from Congress in 1987 was to serve as a proponent for rural interests in the Department's health care policy process. The office has a specific mandate to review HCFA proposals and regulations, to maintain an information clearing house, and to provide information on rural health activities in other federal agencies.

The Office of Rural Health Policy is the only office in the Department solely concerned with rural health care needs. It is active in coordinating rural health care programs and policies within HRSA, with HCFA, and with many federal agencies such as USDA. Because the challenges to providing adequate care in rural communities are manifestations of many structural issues in the national health care 'system,' the office has become strategically involved in efforts, large and small, to bring about national reforms.

The office engages in a wide spectrum of activity, from research and policy development to constituency-building, to demonstration grants for new rural service delivery systems. The Office administers five grant programs and provides grantees and contractors with technical assistance through workshops, phone conferences, site visits, and other efforts. To cultivate local support for rural health issues, the office has promoted extensive networking among rural health interests within and among the States. This has resulted in a national information network. We support State and regional conferences and lend financial and technical support for new rural health initiatives.

The Rural Health Program includes four components:

2.26: Rural Health Outreach Grants

2.27: Rural Health Policy Development

2.28: Rural Hospital Flexibility Grants

2.29: State Offices of Rural Health

**FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report**

**2.26 Program Title: Rural Health Outreach Grants**

<b>Performance Goals</b>	<b>Targets</b>	<b>Actual Performance</b>	<b>Reference</b>
<b>I. Eliminate Barriers to Care</b> <b>A. Increase Utilization for Underserved Populations</b> 1. Outreach Program: Develop and operate collaborative models of health care services in rural areas which will serve underserved populations.	FY01: 854,000* FY00: 764,000 FY99: 680,000 FY98: 616,000 *numbers represent number of persons served per year	FY 01: FY 00: FY 99: (9/00) FY 98: 630,000	B232
<b>IV. IMPROVED PUBLIC HEALTH AND HEALTH CARE SYSTEMS</b> <b>C. Promote Systems and Infrastructure Development</b> 1. Rural Network Development Program: Improve rural health care access by developing vertically integrated provider networks that involve rural health providers.	FY 01: 270 providers* FY 00: 270 FY 99: 270 *represents number of providers in networks	FY 01: FY 00: FY 99: (9/00)	B232
Total Funding: Rural Health Outreach Grants (\$ in 000's)	FY 2001: \$38,892 FY 2000: \$35,880 FY 1999: \$30,401 FY 1998: \$22,863	B x: page # budget HP: Healthy People Goal	

**2.26.1. Program Description, Context and Summary of Performance**

Rural Health Outreach Grant Program: Rural Health Outreach grants are providing essential health care services to hundreds of thousands of Americans living in rural areas of the country. The goals of the program are to improve access to care in underserved rural areas through the development of new

health care delivery systems that create and sustain greater collaboration among providers. The grants require health care organizations and the communities they serve to develop and implement a consortium with at least three different providers to strengthen existing health care services or bring new services to the community. Services supported by the grants include primary care, mental health, dental care, health education and promotion, health related transportation, mental health, specialty care, school-based clinics and others. Grantees include rural hospitals, clinics, public health agencies, charitable organizations, educational institutions and other non-profit organizations located in rural areas of the country. Target populations include rural minorities, the elderly, pregnant women, children and adolescents, and rural Americans with special needs. The average grant serves over 7000 persons each year. Close to 2.5 million rural Americans have been served by the program since its inception in FY 1991. Over 60 percent of the grantees report a continuation of their activities after federal support is terminated. Grants are for three years. Awards have been made in 46 States and 4 Territories.

**Rural Network Development Grants:** These grants are designed to support the development of vertically integrated provider networks in rural communities. Rural health care providers are finding that they cannot survive in today's health care market without forming alliances with other providers. This program is founded on the belief that locally owned networks of rural providers can improve access to care in rural communities, better coordinate local health care services, and help rural communities respond to the growing presence of managed care. Local ownership and control is more responsive to community needs and more likely to result in systems that will last over time. The typical grant might involve a hospital, local physicians, and long-term care providers. Under this program, the focus is on developing the organizational structure and capabilities of rural networks as opposed to the actual delivery of services. All grantees participate in an evaluation activity that will help us understand more about the development and operation of provider networks in rural areas.

## **2.26.2. Goal-by-Goal Presentation of Performance**

**Goal I.A.1: Outreach Program: Develop and operate collaborative models of health services in rural areas which will serve underserved persons.**

Every Outreach Grant is different. Each has different objectives, different providers, and different target populations. Data from the Outreach Grantees is submitted annually through the grant renewal process and through a special report that grantees are asked to submit in their third and final year. Since every project is different, it has been difficult to aggregate the data.

The data submitted by grantees does provide a rough estimate of the numbers of people served by the grant. The number can be quite large in the case of projects that involve the use of media presentations or distance learning technologies. On the other hand, some projects are providing very specialized

services to a small population (e.g. pregnant women in a community). We are working to design a reporting system that will give us more accurate and reliable data on the numbers of people served by different types of projects and other measures for evaluating the program. This system will be in place by the time new awards are made in FY 2000.

**Goal IV.C.1: Rural Network Development Program: Improve rural health care access by developing vertically integrated provider networks that involve rural health providers.**

In addition to reports received through the normal grants process, the program relies on the Rural Network Development Grant Reporting System. This system provides information on the characteristics of the networks; their organizational capabilities; activities they have taken to strengthen and expand the networks; barriers to network formation in rural areas, and other information. Baseline information on the status of grantee networks was collected in 1998. The second reports from grantees were submitted earlier this year and are under review. An analysis of these reports will be available by early 2000.

Every network is different, so it is difficult to quantify specific results across all grantees. For example, some networks formed in the hope of developing a local managed care product, while others have formed to integrate administrative functions such as billing, purchasing, etc. However, the lessons learned from the experience of these grantees will be quite valuable to other providers seeking to become a part of larger networks in rural areas.

**FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY1999 Performance Report**

**2.27 Program Title: Rural Health Policy Development**

Performance Goals	Targets	Actual Performance	Reference
<b>IV: IMPROVE PUBLIC HEALTH AND HEALTH CARE SYSTEMS</b> <b>A. Improve Information Development and Dissemination.</b> 1. Develop policy relevant research addressing racial disparities and the rural elderly.	FY 01: N/A FY 00: N/A FY 99: 5	FY 00: FY 99: 1 paper on racial disparities completed, 5 on rural elderly underway.	B230
2. Rural Health Policy Development: Conduct and disseminate policy relevant research on rural health issues. (For FY 2000 and 2001, we are focusing on the total set of studies) .	FY 01: 18 research papers FY 00: 25 research papers (5 research studies on the 1997 BBA)	FY 01: FY 00: FY 99: 3 research studies on BBA underway, 5 new BBA studies to be funded	B230
Total Funding: Rural Health Policy Development (\$ in 000's)	FY 2001: \$6,101 FY 2000: \$12,679 FY 1999: \$6,583 FY 1998: \$5,386	Bx: page # budget HP: Healthy People Goal	

**2.27.1 Program Description, Context and Summary of Performance**

This activity supports the policy development functions of the Office of Rural Health Policy. These functions are designed to help policy makers, both in Washington and throughout the nation, better understand the problems that rural communities face in assuring access to health care for their citizens.

Part of this activity, the Rural Health Research Center Program, is the only health services research

program dedicated entirely to producing policy relevant research on health care in rural areas. There are currently five research centers at different locations throughout the country. Each Center has developed its own areas of expertise. One Center is studying the effects of managed care in rural communities, access to managed care by rural Medicare beneficiaries, quality of care issues, and the development of provider networks in rural areas. Another Center is studying the availability of long-term care services in rural areas. A third Center is examining the effects of changes in Medicare payment systems on rural providers, with special emphasis on changes brought about by the Balanced Budget Act of 1997. The other Centers are focusing on rural health care workforce issues and the geography of health care. The work of the Centers is published in academic journals and other venues. The work is widely disseminated by the Rural Information Center (see below) and the State Offices of Rural Health. The emphasis is on studies that will have a timely impact on policy decisions at federal and state levels. For example, one of the Centers produced a paper this year which described the potential impact of Medicare's new prospective payment system for hospitals on small hospitals in rural communities. That study has had a major impact on policy debates related to the new payment system.

In FY 2000, grants to current Research Centers will be ended and new awards will be made to six centers for FY 2001-03. Specific research topics will not be selected until then. Twenty-four projects will be funded with 18 completed in FY 2001, due to multi-year projects.

In addition to the Research Centers, this activity would continue support for: (1) the National Advisory Committee on Rural Health which advises the Secretary on rural health programs and policies; (2) dissemination of rural health information by the Rural Information Center (the Center responds to thousands of inquiries each month and disseminates information through its web site); and (3) small projects that assist the Office of Rural Health Policy and the Health Resources and Services Administration in identifying and clarifying rural health care issues.

#### **2.27.2. Goal-by-Goal Presentation of Performance**

##### **Goal IV. A. 1: Develop policy relevant research addressing racial disparities and the rural elderly.**

##### **Performance:**

Last year we established a performance goal for this program based on the number of papers developed by the Centers specifically addressing issues of racial health disparities among rural minority populations and issues on the rural elderly. It was our intention to make this a priority area for rural health research. In pursuing the area of disparities among minority populations, the Centers have been hampered by a lack of data on rural minorities. Existing national surveys are not particularly helpful for rural minorities and there has been very little effort to collect information by other means. As

a result, very little research has been done specific to rural minorities. Consequently, only one research paper on rural minority health has been published by the Centers in FY 1999. There are 5 studies on the rural elderly either completed or nearing completion, including a focus on long-term care situations and care of patients with Alzheimers disease.

**Goal IV.A.2: Conduct and disseminate policy relevant research on rural health issues.**

**Performance:**

For FY 2001, we are rephrasing the performance goal for the Research Center Grants to focus on the total number of research papers produced by the Centers each year. We think this is a much better measure of overall productivity under the program. The target for FY 2001 is 18 research/analytic papers. Another 6 projects will be funded, but due to their multi-year nature, will not be available until FY 2002.

Within the target, there is an emphasis on policy research concerning the impact of changes in Medicare payment policy legislated by the Balanced Budget Act (BBA) of 1997 and the Balanced Budget Refinement Act of 1999. These changes, which include prospective payment systems (PPS) for outpatient, home health, and skilled nursing facilities, are expected to negatively impact the financial health of rural hospitals. Rural hospitals that operate home health agencies and skilled nursing facilities may be especially vulnerable to these financial reforms. Previous Medicare reforms, such as inpatient PPS, have had large, unanticipated negative impacts on rural hospitals. Legislative reforms, including special payment categories, were enacted to lessen the negative impact on rural areas. Through the policy research on the 1997 BBA, we expect to identify hospitals and rural communities that may be adversely impacted by the new PPS. The research will help not only to predict the impact of the payment reforms on rural hospitals but also to identify options for changes in the new PPS to lessen the negative effects on rural hospitals, their patients, and their communities. Several research studies will focus on the impact of each new PPS individually (for example, the impact of Medicare payment reform on home health care in rural areas). Other studies address the interaction of these PPS changes to examine the total impact on rural hospitals (for example, implications of Medicare payment changes on the viability of rural hospitals). Three research studies on the 1997 BBA were conducted in FY 1999, and five are planned for FY 2000.

**FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report**

**2.28 Program Title: Rural Hospital Flexibility Grants**

Performance Goals	Targets	Actual Performance	Reference
<b>IV. IMPROVE PUBLIC HEALTH AND HEALTH CARE SYSTEMS:</b> <b>C. Promote Systems and Infrastructure Development</b> 1. 100% of eligible states will be participating in the Rural Hospital Flexibility Program.	FY 01: 100% FY 00: 100% FY 99: 90%	FY 01: FY 00: FY 99: 90% (43 of 48 eligible States)	B235
Total Funding: Rural Hospital Flexibility Grants (\$ in 000's)	FY 2001: \$25,000 FY 2000: \$25,000 FY 1999: \$24,992 FY 1998: NA	B x: page # budget HP: Healthy People Goal	

**2.28.1 Program Description, Context and Summary of Performance**

The Rural Hospital Flexibility Grant Program was authorized in the Balanced Budget Act of 1997. The first appropriation for the program was in FY99. The program provides grants to States to help them improve access to essential health care services in rural communities. Grants are awarded to States to: (1) develop and implement a state rural health plan; (2) designate Critical Access Hospitals that will be eligible for cost-based payments through the Medicare Program; (3) assist these Critical Access Hospitals and the communities they serve in developing networks of care; and (4) improve rural emergency services by integrating them with other services in selected rural communities. The program provides support for local citizens, employers, health care providers and other groups to conduct the community-based activities that are necessary to save at-risk rural hospitals and to design better systems to meet local needs. For hospitals and other providers, the program will provide technical assistance and support to: (a) develop integrated networks of care; (b) examine and implement the conversion process for hospitals that wish to be designated as Critical Access Hospitals; and improve information systems, quality assurance programs, and other activities.

### **2.28.2. Goal-by-Goal Presentation of Performance**

#### **Goal IV.C.1: 100% of eligible States will be participating in the Rural Hospital Flexibility Program.**

##### **Performance:**

The first grants to states under this program were awarded in August-September, 1999. Some 43 of 48 eligible States are participating in the program and received a grant for FY 1999. A few States have deferred the decision and will apply for a grant in Fiscal Year 2000.

At about the same time we hope to have in place a technical assistance contractor to work with the states on program implementation and an evaluation program. These two activities will produce information on grant supported activities in the states. The program will be identifying more specifically what is measurable, such as the number of hospital conversions that take place, the types of networks that are developed as part of the conversion process, new strategies for linking emergency services to the Critical Access Hospitals, and other outcomes of the program. Based on that identification, performance measures will be strengthened. We will also have information on how well we are responding to the states in terms of their needs for technical assistance.

**FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY1999 Performance Report**

**2.29 Program Title: State Offices of Rural Health**

Performance Goals	Targets	Actual Performance	Reference
<b>I. Eliminate Barriers to Care</b> <b>A. Increase Utilization for Underserved Populations</b> 1. State Offices of Rural Health: All States will have implemented performance outcome measurement indicators and reported a summary of their outcomes.	FY 01: 50 States FY 00: 32 FY 99: 19	FY 01: FY 00: FY 99: (6/00)	B236
Total Funding: State Offices of Rural Health (\$ in 000's)	FY 2001: \$3,000 FY 2000: \$3,000 FY 1999: \$2,999 FY 1998: \$2,986	B x: page # budget HP: Healthy People Goal	

**2.29.1 Program Description, Context and Summary of Performance**

The State Offices of Rural Health (SORH) program of matching grants supports states to: (1) collect and disseminate information on rural health in their states; (2) coordinate rural health resources and activities statewide; (3) provide technical and other assistance to rural providers and communities; and (4) help communities recruit and retain health professionals. This innovative Federal and State partnership reaches out to provide rural communities with the tools they need to address their health care problems. The State Offices are now playing a major role in implementing the Medicare Rural Hospital Flexibility Program authorized by the Balanced Budget Act of 1997. Most of them will be managing the grants that are being awarded to States for this new program.

**2.29.2 Goal-by-Goal Presentation of Performance**

**Goal I.A.1: All States will have implemented performance outcome measurement indicators and reported a summary of their outcomes.**

**Performance:**

By the end of calendar year 2000, 32 State Offices of Rural Health will have implemented performance outcome measurement indicators. For FY 2001, all 50 will have implemented such a process and will have reported a summary of their outcomes. A report is currently under development on what happened in FY 1999 and is expected to be available in June, 2000.

## **TELEHEALTH**

### **FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report**

The Telehealth Program has been created to coordinate HRSA's telehealth activities. Telehealth is the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration. The Office builds upon and advances HRSA's previous efforts to use telecommunications to improve technical assistance to HRSA's grantees, to more effectively train health care providers, to encourage linkages for knowledge exchange, and to capitalize and replicate lessons learned in providing quality health care to underserved individuals, families, and communities. The Office's responsibilities include telehealth policy and program development, telemedicine demonstrations in medically underserved and hard-to-reach areas, technical assistance to HRSA grantees, and to local and state health officials, and the production of media tools to facilitate the dissemination of health care information to health care providers and the public.

The program included in this section is:

#### 2.30 Telehealth

**FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY1999 Performance Report**

**2.30 Program Title: Telehealth**

<b>Performance Goals</b>	<b>Targets</b>	<b>Actual Performance</b>	<b>Refer- -ence</b>
<b>I. ELIMINATE BARRIERS TO CARE</b> <b>A. Increase Utilization for Underserved Populations</b> 1. Evaluate telehealth programs in urban communities which are designed to overcome barriers to health care for underserved individuals.	FY 01: 1 eval. study FY 00: NA FY 99: 1 study funded	FY 01: (01/02) FY 00: NA FY 99: 1 study funded	B237
<b>IV. IMPROVE PUBLIC HEALTH AND HEALTH CARE SYSTEMS</b> <b>A. Improve Information Development and Dissemination</b> 1. Complete evaluation of rural telemedicine grant program and publish findings.	FY 01: Data collection completed from encounter study and final report produced from both encounter and meta analysis studies; 2 papers submitted for publication. FY 00: Draft survey package submitted to OMB; data collection completed; meta analysis from ongoing individual program evaluations completed; FY 99: 1 paper on interim results	FY 99: Forms revised and limited field test. FY 98: Preliminary forms developed	B237

2. Increase the percent of HRSA grantees that are electronically linked to HRSA.	FY 01: 65% FY 00: 50% FY 99: 35%	FY 01: 01/02 FY 00: 01/01 FY 99: 30%*  * Based on preliminary assessment of HRSA grantees with videoconferencing capabilities	<b>B237</b>
<b>Total Funding: Telehealth</b> (\$ in 000's)	FY 2001: \$ 5,612 FY 2000: \$20,522 FY 1999: \$13,118 FY 1998: n/a	Bx: page # budget HP: Healthy People goal	

### **2.30.1 Program Description, Context and Summary of Performance**

#### **Context:**

Telehealth is the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration. Modern health care increasingly involves the effective use of telehealth technologies to bring care to where the people are. HRSA has established a goal of reaching 100 percent access and 0 percent health disparities. Thus, these technologies are and will continue to be essential tools in achieving HRSA's goal. They are integral to the development of information systems and distance-learning programming that facilitate linkages between health care institutions over distance and provide educational opportunities for those who would otherwise not have or would have difficulty accessing such opportunities. Underserved communities, be they urban or rural continue to face significant challenges in obtaining the financial, physical, and human resources to take advantage of these technologies.

The Agency established the Office for the Advancement of Telehealth in May 1998 to coordinate HRSA's telehealth activities. The Office officially became operational in August of 1998. In FY 1999, it provided HRSA bureaus with technical assistance in the production of distance learning programming and administered 41 grants under the Rural Telemedicine Grant Program and the telehealth grants awarded under the Rural Outreach Grant Program. The latter two programs are authorized under Sections 301 and 330A of the Public Health Service Act, as amended by the health Care Consolidation Act of 1996. These grants are designed to demonstrate the use of telehealth technologies in improving access to health care and access to educational and training programs for health professionals.

The Office also conducted an assessment of HRSA grantee's advanced telecommunications capacity to establish a baseline for the Agency's objective of achieving linkage to 75% of its grantees by FY 2003. Finally, it conducted a pilot project in 7 community health centers and 3 regional offices to assess whether a digital satellite system for low-cost, desk-top videoconferencing would provide adequate connectivity to meet the Agency's objectives. Results of the pilot were evaluated by November, 1999. These results were widely shared within the Agency. Based on the findings from the pilot, an investment strategy is being developed that will allow HRSA's grantee's to communicate via a uniform desk-top video-conferencing network (HRSA Network) by FY 2002 and will ensure that all HRSA grantees have access to the Internet. This network will meet all industry standards for open architecture and interoperability, thereby facilitating connections to other systems within the Department.

Telehealth is an evolving field, reflecting the rapid technological developments in both the computer and telecommunications industries. Keeping up with these changes requires knowledge and skills that often go beyond the experience of any one agency or Department. The Office has been very fortunate in having the opportunity to staff the Joint Working Group on Telemedicine, the federal coordinating group with representation from all federal agencies active in telemedicine. Through this group, it has been able to identify areas of mutual interest with other federal agencies and avoid duplication of effort. The Office is currently collaborating with the Health Care Financing Administration on a study of current Medicare telemedicine payment policies, based on data from the Office's rural telemedicine grantees. Other grantee data has been used to document for the FCC regulatory barriers to the effective implementation of the universal service telecommunications discount program for rural health care providers. The Office also has collaborated with CDC on production of the Healthy People 2000 update for Maternal and Child Health and on a variety of distance learning activities, including the launch of Healthy People 2010. It has embarked on a joint effort with the HHS Office for Disease Prevention and Health Promotion to develop specific criteria by which we will judge whether a non-HHS web site should be linked to those in the Department. In FY 2000, the Office plans to work more closely with the Administration on Aging to promote and evaluate strategies for providing more effective services to the elderly through the use of modern telecommunications and computer technologies.

Within the Agency, the Office has worked closely with the Bureaus in the development of several distance learning initiatives related to quality of care, compliance with Y2K, and rural health. It has established a Distance Learning Working Group to coordinate distance learning activities within the Agency and to assist in evaluation of the pilot project for establishing the HRSA video-conferencing infrastructure. The Office has provided extensive technical assistance to the bureaus in the development of programmatic telehealth initiatives in domestic violence prevention, school-based health, and emergency medical services for children. In FY2000, it plans to work more closely with the bureaus in examining the potential of telehealth technologies for expanding dental services and

services on the Border, and for improving services to the elderly and disabled children's populations through tele-home care.

Perhaps the most important partnerships for the Office are those with our grantees. These partnerships provide critical information on the factors that contribute to or hinder the successful development of telehealth programs in underserved communities. As noted above, the grantees have provided data to HCFA on a number of telemedicine payment issues that are critical to their decisions on reforming the program. Ongoing grantee feedback through the progress reports, business plans, and clinical protocols have proved invaluable in our development of new programmatic initiatives. But perhaps most valuable is the ongoing dialog that occurs among the grantees and between the grantees and the Office through the Rural Telemedicine Listserv, a listserv managed by one of the grantees.

### **Program-wide performance:**

The promise of telecommunications and information technologies for overcoming the barriers to health care of geography, cultural diversity, racial disparities, and poverty has not been realized in many of our most isolated rural and inner city urban communities. The ultimate success of the Office will be in promoting and developing affordable telehealth programs that improve access to health services and to educational and training programs for health professionals who serve these communities. At a very basic level, the increasing demand for technical assistance from the Office is one indicator of Given its responsibilities to develop HRSA's infrastructure for communicating with its grantees, the Office's performance can directly be evaluated by the development of that infrastructure and the extent to which it is used.

### **Program level data issues:**

One of the most difficult challenges in the field of telehealth is defining exactly what is being measured. Telehealth technologies are neither one technology or one application, but a rapidly growing group of health care and distance learning applications that employ diverse telecommunications and computer technologies. Because of rapidly changing technologies, the cost/effectiveness of these programs may be difficult to generalize across programs or over time, but programmatic evaluations should provide valuable information on consumer and provider satisfaction, programmatic costs, utilization, and changes in access and availability of services. The Office has put in place several different data collection strategies to collect the necessary information to broadly assess the factors contributing to the long-term success and viability of telehealth programs in underserved communities. These efforts are described further under the specific objective for improving information development and dissemination (IV.A.1).

## **2.30.2 Goal-by-Goal Presentation of Performance**

**Goal I.A.1 Evaluate telehealth programs in urban communities which are designed to overcome barriers to health care for underserved individuals.**

**Context:**

Despite a growth in investment and increased media attention, telehealth technologies remain largely untested. This is particularly true for applications in urban underserved areas because most of the attention and public monies for telehealth have been focused on the needs of rural communities. Urban residents, especially if they are poor or disabled, face significant barriers to obtaining health services. These barriers can be cultural, economic, and/or related to inadequate transportation. An elderly, poor woman, living in an inner-city and traveling for 1 ½ hours to the specialist via public transportation, faces equally difficult barriers to overcome as one living on a farm.

In FY 1999, OAT managed a pilot project at Drew Medical School to expand tele-ophthalmology screening to other services in inner city housing projects. From this limited study and other similar studies in schools and community-based settings, it is clear that urban projects have the promise of improving access to health services for underserved, inner city population, as well as for expanding the information available on the effectiveness of telemedicine. Most current projects have largely been limited to rural areas, where sparse populations often result in a low volume of services that can be analyzed. By adding information from urban projects, the data available can be expanded to assess the value-added of telemedicine programs and provide support for policy initiatives related to telemedicine.

In the FY 2001 budget, a limited urban initiative is proposed for the Office. This initiative would fund one project that synthesizes and evaluates results from current ongoing urban telemedicine projects in urban inner city communities, comparing and contrasting them with those in rural communities. Based on the results of this project, recommendations will be made for development of a program to foster cost-effective telehealth services for underserved urban populations.

Indicator: Completion of report and recommendations for larger program.

**Performance:**

FY 1999: 1 grant awarded to Drew as a pilot  
FY 2000: 0 grants; Office funding limited to rural projects only  
FY 2001: 1 grant for evaluation

**Data Issues:**

The project will be asked to develop an evaluation framework, conduct a literature survey, develop a listing of rural projects from which to collect information, and prepare a meta-analysis of current findings, both from the published and unpublished literature.

#### **Goal IV.A.1 Complete evaluation of Rural Telemedicine Grant Program and publish findings.**

##### **Context:**

Although telehealth technologies are hardly unique among health services technologies in lacking evidence of their effectiveness, increasingly patients, clinicians, health care facilities, and government and private payers are asking for such evidence. As such, they challenge agencies like HRSA to carefully examine the practicality, value, and affordability of these technologies. This is especially true with regard to underserved communities which can ill afford to invest in technologies that are of little value in improving health care services.

Indicators: Final report and papers submitted/accepted in refereed journals; preliminary reports available both on the web and in print.

##### **Performance:**

In both the FY 2000 and FY 2001 budgets, two evaluations are supported -- a prospective study of encounters in all the rural grantee projects, and a meta-analysis of findings from individual rural telemedicine grant evaluation efforts. The encounter survey provides a potential opportunity to examine changes in programs over time, whereas the meta-analysis provides a way to synthesize findings from individual grantee evaluation efforts that have been underway since. These two studies will be supplemented by data collected in grantee progress reports. The encounter survey was originally to be conducted in FY99, but changes in the actual practice of telemedicine required a complete revamping of the data collection forms, including the development of special forms to document mental health and emergency medical consultations, as well as consultations provided during telemedicine "specialty clinics." As a result, the OMB package for approval of the data collection instruments will not be submitted until Spring 2000. This will delay data collection and the final report. Data from the meta-analysis of grantee data, which was not included in the FY99 Performance Plan, will be available in FY 2000.

FY 1999:	Survey forms significantly revised; new forms for mental health, emergency medical, and specialty clinic services developed.
FY 2000:	Survey forms to OMB for approval; data collection on encounter study begun. Data collection from meta-analysis completed and interim results available.
FY 2001:	Data collection completed from encounter study and final report produced from both encounter and meta analysis studies; 2 papers submitted for publication in refereed journals.

##### **Data Issues:**

Rapid changes in both the telecommunications and computer industries complicate the evaluation of

these technologies. Costs are rapidly decreasing as new applications for the technologies are developed each day.

**Goal IV.A.2: Increase the percent of HRSA grantees that are electronically linked to HRSA.**

**Context:**

The explosion of technology, associated with computers and the Internet, as well as the advent of increased wireless communications, require development of new and more timely strategies for the Agency to communicate with its grantees and constituents. And perhaps even more important, the Agency is concerned that without a concerted effort on its part, including investments, many of its grantees will not have either the technical or fiscal resources to invest in the technologies they need to remain current in their fields. Thus the Agency developed the strategic goal that by 2003, at least 75% of its grantees are electronically linked to HRSA so as to be able to participate in distance learning, transmit medical data electronically, and link their staff and patients with experts in distant communities.

Indicators: Number and percent of HRSA grantees that have videoconferencing capabilities.

Percent of HRSA grantees that are linked to the Internet.

**Performance:**

Although several indicators could have been chosen, we have selected videoconferencing capability as an excellent indicator of a grantees electronic linkage capabilities. In particular, low cost desk-top videoconferencing systems provide grantees with capabilities to more easily participate in a range of distance learning, information sharing, and depending on the clinical service, significant exchange of clinical information. In FY 1999, HRSA assessed the telecommunications and computer capabilities of its current grantees. In brief, the assessment found that only 30% of HRSA grantees have videoconferencing capabilities in their facilities, although 83% had access to the Internet. Given initial results from the pilot study, it would seem feasible to initiate an investment strategy in FY 2000. Under one scenario, grantees would use HRSA grant funds to purchase and install the appropriate equipment for connecting to the HRSA videoconferencing Network and the Internet. Acknowledging HRSA's different grant cycles, it is expected that, at a minimum, the target of 65% grantees connected to the Network will be achievable by the end of FY 2001. Beginning in FY 2001, assessments of grantee capabilities would be phased into the applications and progress reports submitted under HRSA's various grant programs.

Baseline (FY 1999): 35% have videoconferencing equipment; 83% connected to Internet

FY 2000:	50% have videoconferencing equipment; 90% connected to Internet
FY 2001:	65% have videoconferencing; 100% connected to Internet

**Data Issues:**

Assessing the extent to which HRSA grantees are linked electronically is a relatively simple exercise, using assessment tools already under development. The key data collection challenge is capturing the actual usage of the network since once in place, the network can and should be used to meet a wide range of communication needs, not just communication with HRSA. A possible indicator of use might be the percent of HRSA grantees registered to participate over the Network in at least one HRSA-sponsored distance learning or technical assistance activity quarterly. Another indicator would be the percent of HRSA grantees that submit their progress reports electronically.

## **TITLE X - FAMILY PLANNING**

### **FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY1999 Performance Report**

The Title X program is the only Federal program solely committed to reproductive health, with a primary function of reducing unintended pregnancy through the provision of a broad range of effective and acceptable family planning methods and services on a voluntary and confidential basis to all persons desiring such services. Other sources of funding supplement the Title X grant program to support the total cost of client care. Altogether in 1998, Title X service grantees reported total revenues of \$708 million to support the provision of family planning services, serving 4.4 million clients. Half of these funds come from federal sources, including federal grants (including 25 percent from Title X grants) and Medicaid reimbursements. The remaining half of all revenues come from other sources such as state and local funds, patients fees and third party collections. The distribution by funding source varies by regions.

The Title X program also supports three key functions aimed at assisting clinics in responding to clients needs: (1) training for family planning clinic personnel through general training programs, as well as training for clinicians; (2) information dissemination and community-based education and outreach activities; and (3) research to improve the delivery of family planning services.

The program is administered by the Office of Population Affairs (OPA) within the Office of Public Health and Science (OPHS), although its budget line is located within the Health Resources and Services Administration (HRSA) appropriation. Therefore, the OPA family planning program efforts are reflected in two performance plans -- (1) generally described in the program office contributions toward the priorities contained in the OPHS performance plan and (2) in the detailed program specific measures contained in the HRSA-wide performance plan.

The program included in this section is:

#### **2.31 Title X - Family Planning**

**FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report**

**2.31 Program Title: Title X- Family Planning**

<b>Performance Goals</b>	<b>Targets</b>	<b>Actual Performance</b>	<b>Reference</b>
<b>I. ELIMINATE BARRIERS TO CARE</b> <b>A. Increase Utilization for Underserved Populations</b> 1. Increase the number of service demonstration grants in the family planning program focusing on underserved populations, including males, adolescents, substance abusers incarcerated populations.	<b>Male Grants</b> FY 01: 15 (revised) FY 00: 15 (revised) FY 99: 15  <b>Adolescent Grants</b> FY 01: 8 (revised) FY 00: 8 (revised) FY 99: 8  <b>Substance Abuse Grants</b> FY 01: 3 FY 00: 1 (revised) FY 99: 1  <b>Incarcerated Grants</b> FY 01: 6 (revised) FY 00: 3 (revised) FY 99: 3	FY 01: FY 00: FY 99: 15 FY 98: 17 FY 97: 10  FY 01: FY 00: FY 99: 8 FY 98: 15 FY 97: 10  FY 01: FY 00: FY 99: 1  FY 01: FY 00: FY 99: 3 FY 98: 1	B244

Performance Goals	Targets	Actual Performance	Reference
<b>C. Focus on Target Population</b> 1. Increase the number of individuals served by Title X clinics.	FY 01: 5.75 million FY 00: 5.25 FY 99: 6.0	FY 01: FY 00: FY 99: 5.0M est. (11/00) FY 98: 4.283 FY 97: 4.362 FY 95: 4.400 million	B244
<b>IV. IMPROVE PUBLIC HEALTH AND HEALTH CARE SYSTEMS</b> <b>B. Promote Education and Training of the Public Health Workforce</b> 1. Improve skill level of all clinic personnel through continuing education	FY 01: 21,000 trained FY 00: 21,000 FY 99: 21,000	FY 01: FY 00: FY 99: FY 98: 21,000	B244
<b>Total Funding: Family Planning</b> (\$ in 000's)	FY 2001: \$273,932 FY 2000: \$238, 932 FY 1999: \$214,932 FY 1998: \$202,903	B x: page # budget HP: Healthy People goal	

### **2.31.1 Program Description, Context and Summary of Performance**

The Title X program is the only Federal program solely dedicated to family planning and reproductive health with a mandate to provide “a broad range of acceptable and effective family planning methods and services.” The program supports a nationwide network of over 4,600 clinics and provides reproductive health services to approximately 4.4 million persons each year. In addition to contraceptive services, Title X also supports a broad range of prevention-oriented reproductive health care activities, including counseling, routine gynecological care, hypertension screening, reproductive cancer screening, and testing and treatment for sexually transmitted diseases.

Title X service funds are allocated to the ten DHHS Regional Offices which, in turn, manage the competitive review process, make grant awards and monitor program performance. In 1999, eighty-

three service grantees, including States, family planning councils, Planned Parenthood affiliates and other public and private entities provided comprehensive family planning and reproductive health services to a nationwide network of clinics. Forty-nine grantees are State or local health departments.

The Title X program also supports three key functions aimed at assisting clinics in responding to client needs: (1) training for family planning clinic personnel through programs in each of the ten DHHS regions, as well training programs focused on health practitioners; (2) information dissemination and community-based education and outreach activities; and (3) research to improve the delivery of family planning services.

The program enacted in 1970 as a response to socioeconomic disparities in unintended pregnancy, gives priority to low-income persons and is based on principles of voluntariness and comprehensiveness. Title X-funded services, available regardless of ability to pay, help ensure access to necessary reproductive health care for poor and low-income persons, a population which is disproportionately composed of racial and ethnic minorities. Title X has also long served as an entry point into the health care system, as well as a source of primary health care services, for this population. Additionally, the sexuality and contraceptive counseling and services available in all Title X funded clinic settings promote responsible sexual behaviors, as well as help couples space births and plan intended pregnancies, an important element in ensuring positive birth outcomes and a healthy start for infants.

In FY 2001 the program is committed to improving and expanding service delivery for its target population, addressing HIV prevention among women, and increasing utilization of services for underserved populations. An increasing demand for subsidized reproductive health services, coupled with advancing technologies require substantial Title X service expansion if the program is to remain accessible and maintain high standards of care. In addition, Title X serves a population at increasing risk for HIV infection -- young, low-income and minority women. The program already has both the clinical facility and focus necessary to deliver effective HIV prevention services and it is imperative that a concerted prevention effort in this area be undertaken. Finally, social and cultural barrier to reproductive health services still exist for many populations. Title X currently has a number of initiatives in place to reach these underserved groups and plans to continue to expand them.

The Title X family planning program works in partnership with a variety of Federal and external partners, including State and local governments, national professional organizations, community-based organizations, and minority organizations. Collaboration will continue as we continue to work with existing partners and pursue new linkages. Examples of family planning partnerships include:

- Ongoing collaborative efforts with CDC in regional infertility prevention projects and HIV training in family planning clinics.

- Membership in the STD Prevention Partnership, a public-private consortium, managed through CDC.
- Sponsorship of activities with crosscutting benefits such as funding for and analysis of data from the National Survey of Family Growth (NCHS/CDC), the National Survey of Adolescent Males (Urban Institute) and the ADD Health Survey (NICHD/NIH).
- Projects with community-based organizations to examine ways in which to deliver reproductive health services to adolescent and young men.
- A partnership with the Bureau of Prisons, DOJ, to develop a pre-release videotape on health issues, including reproductive health, for individuals re-entering the community.
- Contributing partner to the SAMHSA national conference on women which brings together multiple disciplines to promote the health and well-being of women affected by substance abuse and mental illness.

### **2.31.2 Goal-by-Goal Presentation of Performance**

**Goal I.A.1 Increase the number of service demonstration models in the family planning program focusing on underserved populations including males, adolescents, substance abusers, incarcerated populations and the homeless.**

#### **Context:**

Even if all clients were insured, social and cultural barriers to accessing services still exist for many populations. These underserved populations include males, adolescents, substance abusers, the homeless and incarcerated persons. The Title X program will continue and expand its ongoing efforts to increase utilization of services for males and adolescents, as well as to begin new efforts on behalf of other populations, including substance abusers, the homeless and incarcerated populations. In FY 2001, the OPA plans to further expand this effort through targeted emphasis on underserved populations.

Males – The family planning program is committed to increasing services to males, emphasizing shared responsibility for preventing unintended pregnancy and STD/HIV infection. Title X is required, by statute, to provide reproductive health services to all persons who desire them; service data consistently show that only 2 percent of persons receiving Title X services are male. One important reason for this failure to recruit and serve males, despite growing a consensus that it is essential to do

so, is the fact that reproductive health services have been traditionally targeted to women and it has been extraordinarily difficult to draw men into the clinical setting. In response to this, in FY 1998, a total of 17 community-based organizations, already providing a variety of services to males, have been funded through the Title X program to examine ways to deliver reproductive health education and services to adolescent and young men.

Adolescents – The Title X program intends to place increased emphasis on services to adolescents, including education and counseling to postpone initiation of sexual activity and more accessible provision of contraceptive counseling and services for those who are already sexually active. Title X, through both statute and regulation, is well placed to provide these services. The program is required to provide comprehensive reproductive health services to *all* persons who desire them; there are no restrictions by age or by type of service. Currently, approximately 30 percent of those receiving services in Title X clinics are less than 20 years of age—most are already sexually active and are thus receiving family planning counseling and services. There is still, however, a large segment of the adolescent population who are either not yet sexually active and could benefit from counseling to continue postponing sexual activity, or who have recently become sexually active and need counseling and services to prevent unintended pregnancy and STD/HIV infection.

Substance Abuse, Homeless and Incarcerated Populations – Other underserved populations to be addressed include substance abusers and homeless and incarcerated persons. In finding effective ways to overcome barriers to services experienced by these multi-problem clients, the Title X program will research and develop focused information and education materials, communication and outreach strategies specific to targeted populations, ways to meet unique service delivery requirements, and opportunities for partnerships with entities that have related interests and that work with similar populations.

### **Performance:**

OPA and regional reports indicate that the number of hard to reach grants has remained fairly constant. The targets for male, adolescent and substance abuse projects have been revised to reflect actual grants, rather than project activities. The measure for homeless projects has been deleted since these are project efforts conducted as part of ongoing service grants, and are not identifiable as a distinct special population grant. The program is planning to expand on these ongoing efforts to serve male and adolescents. and to begin new efforts with other hard-to-reach populations. The number of grants number of grants is expected to remain constant, but the number of hard-to-reach projects is expected to increase (grantees may have multiple subcontractors or projects).

Indicator: Number of service demonstration models focusing on underserved populations, including male, adolescents, substance abusers, incarcerated and homeless.

**Data Issues:**

Information was gathered by a review of grants funded by the Office of Population Affairs and by direct inquiry to the regional offices. With the expansion of special projects, the Title X program intends to develop more specific measures other than just the number of grants. The program will be exploring mechanisms for obtaining more uniform and detailed information about the types of services provided in these special grants, as well as the clients served.

**Goal I.C.1 Increase the number of individuals served by Title X programs. (Baseline: 4.4 million women served in FY 1995).****Context:**

The fundamental purpose of the Title X program is to provide reproductive health education and services to all persons who desire them. Substantial service expansion is necessary if the program is to remain accessible to increased numbers of clients and maintain its high standards of care, as well as cope with the rising costs of providing services. Other sources of revenue supplement the Title X grant program to support the total cost of client care. Nationally, half of these revenues come from federal grants (25% from Title X) and Medicaid. The other half of all family planning revenue comes from State and local sources, patient fees and private insurance. To increase the number of individuals served, it is essential that Title X program continue to partner with other funding sources in order to support the overall cost of client care.

Title X family planning providers continue to struggle to provide quality contraceptive and reproductive health care to as many people as possible, and several significant factors have played a role in the constant levels of clients reported served in the program. As the population needing subsidized reproductive health care expands, due in part to the growing number without public or private health insurance coverage, demand for Title X services has also increased. These services are provided without regard to an individual's ability to pay, and if the person's income is below the poverty level, the services are free of charge. The relatively high – and increasing – cost of the most effective contraceptives, particularly hormonal implants and injectables, impacts on the program's ability to expand services to more clients. These methods are extremely effective but have high up-front costs as compared to oral contraceptives. Providing one woman with an injectable for a year is more expensive than providing three women with an annual supply of oral contraceptives – making it difficult to accommodate new clients. The higher cost for skilled personnel and advanced diagnostic technologies also contribute to the increase in the overall cost of providing services. The rising costs of pap smears and improved STD screening and detection techniques make it difficult to provide such services to all clients.

**Performance:**

For the baseline year 1995, Title X reported serving 4.4 million persons. 1997 and 1998 data from

the Family Planning Annual Report (FPAR) show the overall level of family planning users remaining constant. 1999 data on family planning users will be available in the Fall, 2000. The estimated targets have been revised to reflect more realistically the fact that the overall number of clients nationwide has remained stable in recent years and is not expected to increase without targeted resources. The FY 00 target is based on a new projected FY 99 performance of 5.0 million. The program has received a substantial increase of \$25 million in FY 2000 with the goal of serving substantially increased numbers of clients. For this goal to be met it is essential that Title X family planning programs continue to partner with other funding sources in order to support the overall cost of client care.

Baseline:       FY 1995: 4,400,686  
                  FY 1996: 4,451,151  
                  FY 1997: 4,362,520  
                  FY 1998: 4,283,559  
                  FY 1999: 6.0 million\* (est. 5.0 M)  
                  FY 2000: 5.25 million\* (Revised from 6.5 million)  
                  FY 2001: 5.75 million

#### **Data Issues:**

Considering the increased demand for Title X subsidized services, the characteristics of the populations most in need of services and the increasing costs for providing those services, it is becoming quite clear that measuring program performance on client counts alone is not adequate. Thus, the program will be considering revisiting the program goals, as well as revisions to the data collection system to capture better program information.

#### **Goal IV.B.1 Improve skills level of all clinic personnel through continuing education.**

##### **Context:**

Consistent with its mandate, Title X supports training programs designed to enhance the quality of family planning services providers. The program supports two types of training activities: (1) support for general training and specialized technical assistance available to all family planning personnel assistance and (2) training specifically designed for clinical personnel.

Since the early 1970s, the Title X program has supported certificate nurse practitioner programs to prepare registered professional nurses in Title X agencies. However, several changes have resulted in a shift in the program's approach to training clinical providers for the Title X system. Given the declining number of applicants for Title X nurse practitioner training over the past five years, and the fact that States moving toward requiring a masters degree for nurse practitioner practice, certificate

training of nurse practitioners for Title X agencies will no longer be a viable option. In recognition of these changes, and in an effort to maintain and enhance the quality of family planning service delivery in the Title X system, the traditional nurse practitioner training is being phased out and replaced with a program of specialty training. The specialty training will provide in-depth family planning and women's health information and clinical training to a broader range of health care providers (such as masters prepared family or adult nurse practitioners, physicians assistants, Doctors of Medicine or Doctors of Osteopathy). As the nurse practitioner training phases out and the specialty training programs begin implementation, we will be better able to assess the number of specialty courses offered, the content of that training, and the numbers and types of providers being trained.

### **Performance:**

For FY 1999 and FY 2000, no increase was projected in the number of clinical personnel to receive training, based on a shift in training priorities. Additional emphasis is being placed on training around electronic technology and distance learning which will require specialized training techniques. Reports from the regional offices show that the numbers of trainees is remaining relatively constant.

FY 1998: 21,000 clinic personnel obtained training

FY 1999: 21,000

FY 2000: 21,000

FY 2001: 21,000 target

Indicator: The number of individuals participating in Title X general training programs.

### **Data Issues:**

Both the general training and the nurse practitioner training programs are undergoing changes which will affect our ability to measure this goal. In order to more efficiently address the change in training needs for each individual region, the we recently shifted administration of the Title X general training grants from OPA to the regional offices.

### **Data Collection and Validation:**

#### **C      Number of Title X Service Clients – Family Planning Annual Report**

All service grantees receiving funding under the Title services program are required to submit annual data on the number of family planning users by selected demographic characteristics, contraceptive method adopted or used at the time of last visit, number of Pap smears, breast exams and STD tests, staffing profiles, and funding sources. The responsibility for the collection and tabulation of annual service data from Title X grantees rests with the Office of Population Affairs, which is responsible for the administration of the program. Reports are submitted annually on a calendar year basis (January 1 - December 31) to the regional offices.

Grantees reports are tabulated and an annual report prepared summarizing the regional and national data. The annual reports present information on the methodology used both in collection and tabulation of grantee reports, as well as the definitions developed and provided by OPA to the grantees for use in completing data requests. In the 1998, national totals and regional highlights are discussed and, in some cases, trends between 1995 and 1998 are mentioned. Also included in the report are lengthy notes that provide detail regarding discrepancies between what OPA requested and what individual grantees were able to provide. All data inconsistencies and their resolution are noted in an appendix to the report. These are included for two reasons: (1) to explain how adjustments were made to the data, and how discrepancies affect the analysis and (2) to identify the problems grantees have in collecting and reporting the requested in hope of improving the process.

## HEALTH CARE ACCESS FOR THE UNINSURED

### FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report

#### 2.32 Program Title: Health Care Access for the Uninsured

Performance Goals	Targets	Actual Performance	Reference
<b>I. ELIMINATE BARRIERS TO CARE</b> <b>A. Increase Utilization for Underserved Populations</b> 1. Increase the number of new integrated health services networks that are providing care using report card information to integrate and improve health services for the uninsured.	FY 01: Developmental FY 00: Developmental FY 99: NA	FY 01: FY 00: FY 99: NA	B248
2. Increase the number of uninsured people receiving primary care, mental health, substance abuse and other health services and expand the number of services supported.	FY 01: Developmental FY 00: Developmental FY 99: NA	FY 01: FY 00: FY 99: NA	B248
<b>III. ASSURE QUALITY OF CARE</b> <b>A. Promote Appropriateness of Care</b> 1. Reduce, where appropriate, hospital admissions for ambulatory-sensitive conditions for uninsured people living in project service areas.	FY 01: Developmental FY 00: Developmental FY 99: NA	FY 01: FY 00: FY 99: NA	B248

Performance Goals	Targets	Actual Performance	Reference
<b>Total Funding: Health Care Access for the Uninsured</b> (\$ in 000's)	FY 2001:\$ 125,000 FY 2000: \$ 40,000 FY 1999: -- FY 1998: --	B x: page # budget HP: Healthy People goal	

### **2.32.1 Program Description, Context and Summary of Performance**

The Health Care Access for the Uninsured program is a new program in FY 2000 and is expanded in the FY 2001 budget. This program consists of two components designed to address the problem of uninsured individuals:

- C Community Access Program: Designed to increase the capacity and effectiveness of the Nation's variety of community health care institutions and providers who serve patients regardless of their ability to pay (\$25 million in FY 2000; \$125 million in FY 2001).
- C State-Based Program: Supports grants to States to develop designs for providing access to health insurance coverage to all residents of the State (\$15 million in FY 2000).

Community Access Program: These funds will enable public, private, and non-profit health entities to assist safety-net providers develop and expand integrated systems of care and address service gaps within such integrated systems with a focus on primary care, mental health services and substance abuse services. This competitive grant program is a multi-year initiative designed to increase the capacity and effectiveness of the nation's health care safety-net, those health care institutions and providers who serve patients regardless of their ability to pay. In FY 2000, \$25 million will enable public, private and nonprofit entities to assist safety net providers expand integrated systems and fill services gaps. The grant program's overall goal is to assure that more uninsured people receive needed care with a focus on primary care and behavioral health services, the care received is of higher quality, and the uninsured are served by providers who participate in accountable health systems.

Grants will provide funds to public and private entities to enhance the ability of safety-net providers to offer comprehensive, coordinated health care to a greater number of uninsured people. Funds will be available: (1) to assist safety-net providers to develop and expand integrated systems of care; and (2) within such integrated systems, to address service gaps, with a focus on primary care, mental health services and substance abuse services, with the result that more uninsured individuals will have access to a continuum of core health care services.

Grants under this initiative will support:

- development or enhancement of networks or other coordinated arrangements to provide more comprehensive care to low income uninsured individuals;
- design and establishment of the infrastructure necessary to participate in networks or other coordinated arrangements, including assistance with the establishment of financial systems, patient tracking and other computer systems, and telecommunications systems necessary to appropriately monitor and manage patient needs and to allow safety net providers to compete in the changing market and participate more effectively in commercial and Medicaid managed care plans; and
- financing additional core health services and serving additional uninsured people within integrated systems of care, addressing service gaps identified at the local level.

State-Based Program: FY 2000 funding of \$15,000,000 will support up to 10 new grants to States that have developed designs for providing access to health insurance coverage. Funds will be used to conduct in-depth surveys and other activities necessary to determining the most effective methods of providing insurance coverage for the uninsured. States will submit reports to the Secretary that identify the characteristics of the uninsured within the State and approaches for providing them with health coverage through an expanded state, Federal and private partnership.

### **2.32.2 Goal-by-Goal Presentation of Performance**

#### **Context:**

Community Access Program: The number of uninsured continues to grow. While the State Children's Health Insurance Program offers new opportunities for uninsured children, a large number of adults, roughly 32 million, are uninsured, and of these about 17 million have incomes below 200 percent of the Federal Poverty Level. The burden of care for the low-income uninsured falls disproportionately on safety net providers. At the same time, these providers have had to adjust to the rapid growth of managed care in both private and public insurance programs.

Approaches for improving health services for the uninsured have been developed in a number of communities. While they differ in scope and design, they share the common themes of expanding access to a comprehensive range of services, shifting the focus of care to more efficient settings and emphasizing primary care, and building integrated networks of providers. This program is designed to foster such community-based approaches.

#### **Performance:**

In FY 2000, the first year of the program, funds will be used for 10-20 grants for infrastructure development primarily in locations which have already begun organized community-based efforts to coordinate services provided to the uninsured. A small percentage of funding may be devoted to

service delivery at these or other sites where coordinated systems are being developed. In FY 2001, \$125 million is requested. This new funding will support continuation funding at the initial 10-20 sites, where funds will be used primarily for filling service gaps; and for 40-60 new sites where initial funding will be used largely for system development.

Three developmental goals have been identified. Over the first year of the program, efforts will focus on identifying data sources, and determining the extent to which these goals can be tracked based on applicant reporting.

**Goal I.A.1: Increase the number of new integrated health services networks that are providing care using report card information to integrate and improve health services for the uninsured.**

**Goal I.A.2: Increase the number of uninsured people receiving primary care, mental health, substance abuse and other health services and expand the number of services supported**

**Goal III.A.1: Reduce, where appropriate, hospital admissions for ambulatory care-sensitive conditions for uninsured people living in project service areas.**

## PROGRAM MANAGEMENT

### FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Plan

#### 2.33 Program Title: Program Management

Performance Goals	Targets	Actual Performance	Reference
<b>IV. IMPROVE PUBLIC HEALTH AND HEALTH CARE SYSTEMS</b> <b>A. Improve Information Development and Dissemination</b> 1. Financial Statements: Obtain a clean audit opinion for HRSA.	FY 01: Clean opinion FY 00: Clean opinion FY 99: Clean opinion	FY 01: Report 3/02 FY 00: Report 3/01 FY 99: Report 3/00 FY 98: 4 material weaknesses; 10 reportable conditions	B241
2. Information Technology Management: Improve Accessibility to the HRSA Data Warehouse.	FY 01: 100 users FY 00: 60	FY 01: FY 00: FY 99: 10 FY 98: 10 users	B241
<b>C. Promote Systems and Infrastructure Development</b> 1. Assure that all HRSA Systems are Year 2000 compliant.	FY 01: NA FY 00: 14 FY 99: 18	FY 01: FY 00: FY 99: 14 systems FY 98: 15 systems	B241
2. Information Technology Management: Ensure Critical Infrastructure Protection. (Developmental)	FY 01: Developmental	FY 01: FY 00: FY 99:	B241

Performance Goals	Targets	Actual Performance	Reference
<b>Total Funding: Program Management</b> (\$ in 000's)	FY 2001:\$124,353 FY 2000: 124,766 FY 1999: 118,712 FY 1998: 114,059	B x: page # budget HP: Healthy People goal	

### **2.33.1 Program Description, Context and Summary of Performance**

The Health Resources and Services Administration Program Management activity is the primary support mechanism for the Agency that provides national leadership in health care and public health by assuring quality health care to underserved and vulnerable populations and promoting primary care education and practice. Program Management supports staff to plan, direct, administer, and provide technical assistance and program guidance to clients of most of the Agency's programs. Specifically addressed are preparation of financial statements, information management and employee development.

**Preparation of Financial Statements:** The management of the Health Resources and Services Administration is responsible for complying with laws and regulations applicable to HRSA. Among these are the provisions of the Chief Financial Officers Act which mandate that the Department prepare an annual accountability report on its performance and financial integrity. The basis for the HRSA accountability report is an annual audit of the Agency's financial status by a commercial public accounting firm. The *HRSA Chief Financial Officer's Annual Report* is prepared for submission by March 1 of each year for the previous fiscal year by the Division of Financial Management, Office of Management and Program Support with the assistance of the Division of Financial Operations, Program Support Center which provides accounting services to HRSA.

**Information Technology Management:** (1) provides advice and assistance to the Administrator and other senior management personnel to ensure that information technology is acquired and information resources are managed in a manner that implements the policies and procedures of the Clinger-Cohen Act and the priorities established by the Secretary; (2) develops, maintains, and facilitates the implementation of a sound and integrated information technology architecture for the agency; and (3) promotes the effective and efficient design and operation of all major information resources management processes for the agency, including improvements to work processes of the agency.

**Quality of Work Life (QWL) Initiative:** HRSA's plan is divided into three (3) sections: Employee

Development; Employee Health and Fitness; Workplace Improvement. To implement the plan, HRSA has appointed a 23-member QWL Implementation Team, with representation from headquarters and the field. The work of the Implementation Team is conducted within 3 sub-groups, which focus on the 3 subject areas. A major focus is on increasing investment in workplace learning. Through the HRSA Career Resources Center, employees have access to workshops, printed materials and computer programs which increase their participation in workplace learning. The CRC staff is continuing to develop workshops to address the issues identified in the Training Needs Assessment, including leadership, coaching, time management, and mentoring. Through a contract with Loyola College, HRSA gives employees the opportunity to participate in classroom instruction designed to enhance their job skills and knowledge. HRSA is also offering a number of special opportunities across the Agency including Master of Business Administration (MBA) programs and women's leadership programs.

### **2.33.2 Goal-by Goal Presentation of Performance**

#### **Goal IV.A.1: Financial Statements: Obtain a clean audit opinion for HRSA.**

##### **Context:**

During FY 2001, the Health Resources and Services Administration (HRSA) plans to obtain a clean audit opinion consistent with the objectives of the Department of Health and Human Services and the President and in accordance with the Chief Financial Officers Act. The annual audit helps ensure the integrity of the Agency's financial systems and the reliability of the financial data provided to HRSA by the Program Support Center (PSC). HRSA continues to be committed to providing accurate, comprehensive information for Federal policy and program decisions.

As with any business or government enterprise, delivery of an audit report which is timely and complete is a crucial part of the management information system and an important tool for the direction and implementation of programs. Achievement of a clean audit opinion indicates that the Agency and its accounting service provider (the PSC) have attained a high level of accuracy and reportability in financial records and controls. This achievement provides a solid, rational basis for policy and budget decisions by the Executive Branch and the Congress. Financial Management data is provided by the Division of Financial Management

##### **Performance:**

Baseline: The full, independent audit of HRSA for fiscal year (FY) 1998 was conducted by Clifton Gunderson L.L.C., Certified Public Accountants and Consultants under contract to the Office of the Inspector General. The auditors reported no qualifications to their audit opinion, 4 material

weaknesses, and 10 reportable conditions. All of the material weaknesses and most of the reportable conditions were related to the systems and processes the PSC utilizes in providing accounting services to HRSA.

Actual: the FY 1999 audit was initiated with an audit entrance conference on June 2, 1999. Audit activities commence later in June and proceed to preliminary findings in December 1999. The *HRSA Chief Financial Officer's Annual Report* for FY 1999 will be submitted by March 2000 for incorporation in the *DHHS Accountability Report: Fiscal Year 1999*.

During the course of the FY 1999 audit HRSA worked closely with the PSC to improve, enhance and correct those accounting, data and procedural elements which led to material weaknesses and reportable conditions in previous audits. One adjustment has been to stagger the scheduling of the HRSA audit from the audits of other OPDIVs provided accounting services by the PSC in order to assure that both the PSC financial operations staff and the auditors have sufficient time and human resources to thoroughly investigate and examine all relevant data and accounts. HRSA tracks the progress of the audit through the assignment of a Division of Financial Management staff member to provide oversight in frequent scheduled and *ad hoc* meetings and reviews.

Planned: The Secretary has declared the achievement of an unqualified audit as an objective for the Department consistent with goals expressed by the President and the Office of Management and Budget. This similar performance objective of HRSA is supportive of the Secretary's intent and will provide management and policy officials with accurate, comprehensive information on which to base funding and operating decisions. The objective will also lead to improvements in HRSA's accounting and other financial systems and to improvements in the quality of such services provided to the Agency by the PSC.

### **Information Technology:**

#### **GOAL IV.A.2: Information Technology Management: Improve Accessibility to the HRSA Data Warehouse**

During FY 2001, HRSA plans to establish agency-wide, desktop-access to the Data Warehouse. The Data Warehouse includes valuable information obtained from HRSA grant programs, U.S. Census Bureau, and other health-related and statistical data (such as the American Medical Association, American Association of Nursing, etc.). Access is defined to include the entire staff of HRSA employees that are required to perform data manipulations and have been granted the appropriate data access rights. The mechanism for providing access to the Data Warehouse will likely be the internet or intranet.

The Data Warehouse supplies an agency-wide information architecture that integrates program data into a warehouse structure. "Data warehousing" is defined as an essential set of enabling information systems through which to achieve key business objectives.

By eliminating duplicate data collection and validation efforts among individual offices, divisions, and bureaus, the centralized Data Warehouse has provided a cost-effective, value-added contribution to the HRSA enterprise. The Data Warehouse will work better and cost less if HRSA employees collaborate effectively and share information. The broader the scope of information sharing, the greater the benefits will be.

<b>Improve Accessibility to the HRSA Data Warehouse</b>				
<b>Measure</b>	<b>Type</b>	<b>Baseline FY'99</b>	<b>Planned (FY'00)</b>	<b>Planned (FY'01)</b>
Universal access to the Data Warehouse for HRSA employees	Process	10 users	60 users	100 users Full utilization of identified HRSA employees (i.e., those staff granted authority to access the data)

**GOAL IV.C.1: Assure that all HRSA Systems are Year 2000 compliant.**

**Context:**

HRSA realizes that it must ensure the availability of the services it provides by putting in place an operating infrastructure that adequately facilitates its mission and that remains operational in the event of unexpected catastrophes. One threat to the IT installations is the Year 2000-induced failures that could interrupt the operations of mission-critical systems and core business processes.

HRSA has completed Independent Validation and Verification (IV&V) testing of five mission critical systems: Organ Procurement Transplantation Program, BCHDAnet, National Practitioner Data Bank, Health Education Assistance Loan Program, and the Grants Electronic Management System. Additionally, HRSA developed business continuity and contingency plans and Day One response plans to ensure that the core business processes and mission critical systems remained operational on January 2, 2000.

Additionally, HRSA completed the testing of all web servers, network servers, and Local Area Networks (LANs). Servers that were found to be non-compliant with Y2K standards were replaced or appropriately repaired. Other shared resources such as power, communications, infrastructure, and facility equipment (elevators, HVAC, etc.) are the primary responsibility of the Program Support Center (PSC).

**Performance:**

Overall, HRSA systems performed properly after December 31, 1999.

FY 99: 18 systems\* (For FY 99, a more current estimate is 14)

FY 00: 18 systems\* (Revised to 14)

FY 01: NA

\* Revisions:

	<b>FY 1998</b>	<b>FY 1999</b>	<b>FY 2000 Planned</b>
Mission Critical Systems that are Compliant	3	5	5
Non-Mission Critical Systems that are Compliant	12	9*	9
Total Compliant Systems	15	14	14
	* In FY'99, several non-mission critical systems were retired and are not included in the above FY'99 reporting		

**GOAL IV.C.2: Information Technology Management: Ensure Critical Infrastructure Protection (Developmental)**

**Context:**

As a result of advances in information technology, HRSA has grown increasingly reliant upon critical infrastructures and cyber-based information systems. The growing dependency on web-based information exchange and enterprise applications results in the exposure of critical HRSA infrastructures to new vulnerabilities. By Fiscal Year 2001, the Office of Information Technology (OIT) plans to reduce the vulnerability of critical HRSA infrastructures by conducting periodic penetration testing and vulnerability scanning of specific systems, establish incident detection requirements and reporting procedures, conduct security awareness and training programs for IT

professionals, senior management, and end-users, and deploy intrusion detection systems.

Ensure Critical Infrastructure Protection		
Measure	Baseline	Planned FY'01
Reduce the number of security violations that create a major risk to the HRSA technical infrastructure	TBD	Ten percent (10%) reduction (from the previous year) in the number of major security violations to the HRSA infrastructure

## APPENDIX TO THE PERFORMANCE PLAN

### A.1 Approach to Performance Measurement

HRSA has made a strong effort to build a performance management approach into the way it conducts its business. The agency structured the development of its internal strategic planning process to be consistent with the requirements of the Government Performance and Results Act (GPRA). The goals developed in the process have guided the development of our Annual Performance Plans. This Annual Performance Plan includes a FY 2001 Plan, a FY 2000 Final Plan and the FY 1999 Performance Report.

HRSA initiated its GPRA performance measurement effort with an assessment of all programs and their readiness for measuring performance, beginning with the GPRA requirements as the basis for the review. The Agency, using each major program budget line:

- C Identified both strengths and weaknesses in terms of ability to measure performance.
- C Assessed the current availability of indicators and data that can be used to ensure effective management of resources.
- C Identified key areas where developmental activities are needed and have channeled agency resources to these areas.

The agency outlined the central assessment question of organizational performance:

*Can this organization, with a given set of resources, through a series of actions and decisions, produce outputs that have the desired effects and outcomes to benefit those it serves?*

Technical assistance has been provided to each of the operating components to enhance ability to define performance goals and measures. For the FY 2001 budget, Annual Performance Plans are included for all major program activities.

## The Essential Performance Question

Can this organization	...with these resources...	...through these actions, processes and decisions...	...yielding these products...	...have these effects...	...for these people?
HHS  HRSA  4 Bureaus  Programs  Activities	Legislative Authority  Budget Authority  Staff  Equipment/Supplies  Information and Data Systems	Data Collection  Research/Analysis  Problem/Needs Assessment  Methods Development  Standard Setting  Grant-making  Contract Awards  Program Coordination	Service Delivery  Training  Technical Assistance  Demonstrations/Experiments  Knowledge/Awareness  Skill/Capacity  Guidelines	Access to Care  Improved Utilization  Improved Quality  Lower Mortality/Morbidity  Increased Life Expectancy  Improved Health Status	Vulnerable Populations  Medically Underserved  Persons with HIV/AIDS  Children with Special Health Care Needs  Persons in Border Communities

Organization Input

Process

Output

Outcome

Customers

Level

The plan contains a mix of process, output, and outcome indicators. Basic distinctions among these are as follows:

- C **Process:** A program's internal activities (e.g., training approach used).
- C **Output:** A program's direct products or services (e.g., number of people provided health services, number of people trained), including product/service characteristics such as timeliness, quality and efficiency.
- C **Outcome:** Results of program output (e.g., changes in health status, mortality or morbidity).

Although the ultimate target is to produce outcome-oriented performance goals, since these are the desired indicators of program results, it should be recognized that output and process measures are also important and frequently the most realistic indicators of performance. They are often the only indicators currently available on an annual basis and reflect the level of control an agency can bring to bear through particular programs. HRSA will work to increase the use of outcome measures and to demonstrate the relationship between its process/output measures and the desired outcomes.

Throughout the HRSA plan, there are performance goals of each of these types. Within the Maternal and Child Health program, for example, outcome measures are emphasized. Data will be collected on core performance measures from all States, including tracking of the infant mortality rate and the disparity between the black and white infant mortality rate. The Bureau of Health Professions has developed a Comprehensive Performance Monitoring System which will begin to capture common activities across its programs and to measure the aggregate effects of grantee achievements. An example of such a cross-cutting goal is to increase the number of graduates and/or program completers who enter practice in underserved areas.

## **Data Verification and Validation Issues:**

### **General**

There are numerous concerns about the availability and cost of data to measure performance and results. Data systems often have been initiated to measure the results of individual programs, usually as a legislated requirement. Many programs target the same populations within and outside of HRSA, so there is the potential for individual programs trying to obtain different information, in different formats and at different times, from the same source, thereby increasing the reporting burden at the grantee level.

Because HRSA programs are generally carried out by grantees at the State and local level, who often use subgrantees or contractors to perform the work, the system is not structured to produce a routine flow of data on grantee performance and outputs. HRSA is working to establish useful and efficient systems for gathering performance and accountability information. Another data issue is the competing need to collect essential performance measurement information while, at the same time, attempting to meet the requirements of the Paperwork Reduction Act which aims to reduce the reporting burden associated with participation in Federal programs. These competing needs at times are difficult to resolve. This variety of data issues will continue to be addressed as we proceed with the development of our performance measurement strategy.

It is clear that additional effort is needed to move toward increased use of common, structured, and standardized data strategies to carry out an effective system of performance measurement. A good deal of work has already been initiated in this area.

## **Primary Care**

### **(Bureau of Primary Health Care)**

#### **A. General Description of the Sources/Systems**

In order to prepare for the implementation of GPRA, several years ago the Bureau of Primary Health Care initiated a three-part data and evaluation strategy. First, a Uniform Data System (UDS) was developed and implemented to collect aggregate administrative, demographic, financial, and utilization data annually from each organization receiving support. This system, which combined five previously separate reporting formats, is in its fourth year of operation providing standardized information across all grantees for all years.

The Bureau's second part of its data and evaluation strategy uses surveys (User Visits Surveys) of a representative sample of health center users and provider visits developed in collaboration with the National Center for Health Statistics. These surveys provide in depth information on individuals and the care they receive based on and comparable to the National Health Interview Survey (NHIS) and the National Hospital Ambulatory Medical Care Survey, (NHAMCS), respectively. The use of instruments from already established surveys assures the collection of reliable and comparable data on health center users. National results are used as benchmarks of program performance. This survey will be conducted again in FY 2000 and will be expanded to include sites at which National Health Service Corps (NHSC) clinicians serve.

Third, BPHC reoriented its portfolio of other evaluation efforts, shifting from a descriptive case-study approach to the use of previously validated secondary data sources that enable a comparison of users and similar populations of non-users, and systematic sampling of organizations and users. One such study uses State Medicaid Research File data from HCFA to identify ambulatory care sensitive conditions (ACSC; a proxy for access to ambulatory care) to measure differences between Medicaid beneficiary health center users and users of other forms of care. These differences assess the quality of care that users and "non-users" receive. Also in FY 1999, the Bureau has launched Breakthrough Series in Diabetes, Hypertension, and Asthma, the chronic conditions of highest prevalence among health center users. These Collaboratives build appropriate data-gathering and patient management infrastructures within health centers and at NHSC sites to manage, treat, and measure the improvement in user health status with these chronic conditions. These Collaboratives will be expanded to assess preventive strategies such as in tobacco use and smoking cessation and in the management of depression.

## **B. Data Quality**

The UDS is validated through edit checks and onsite reviews conducted during each organization's project period. The "Validity Report" is central to the editing process. This report includes numerous cross-checks of the data including mathematical errors, discrepancies and logical discrepancies both within and between tables. As data are collected over time, internal inconsistencies can be identified and addressed.

The data from UDS directly measure program performance on key GPRA indicators: number of users over time to determine increase in access; and sociodemographic data to assure that programs are targeting the poor, uninsured and members of minority groups to increase their access and eliminate their health status disparities. In FY 1999, the UDS will be expanded to include sites at which NHSC clinicians are serving to obtain a more complete picture of Bureau program impact. These data are used to drive budget decisions at the Agency level. They are also compiled at the Regional level to be used by Field Offices to provide assistance to grantees where necessary.

The results of the User/Visit Survey of 1995 will be compared with the results of the repeat survey in FY 2000. These data provide important measures of the extent to which health centers are eliminating health status disparities. They also provide important "customer" information about satisfaction with care and perceived health status. Currently, most of the GPRA measures of health status disparity reduction rely on these results (e.g., glycohemoglobin tests for diabetics, blood pressure control for hypertensives, up-to-date Pap, clinical breast examination, and mammography for at risk women).

Studies of the data obtained from these Collaboratives will be used to validate the patient-specific data obtained through other methods such as the User/Visit Survey. Also, the data will assure that Bureau performance measures will extend from proxies for outcomes to actual outcomes (i.e., measuring actual glycohemoglobin levels in addition to measuring the percent of health center diabetics who have up-to-date testing at recommended intervals). Individual sites will be able to use these data to assess their own performance over time. The Bureau is working closely with HCFA to expand its ACSC analyses to address the quality of care received by all Medicaid beneficiaries including health center users. These comparisons will enable HCFA to continuously improve the health services delivered to Medicaid beneficiaries at a variety of sites beyond health centers.

The Bureau conducts its own accreditation process which is intended to validate some of the information collected through the UDS. Studies of the data obtained from the Collaboratives will be used to validate the patient-specific data obtained through other methods such as the User/Visit Survey. In sum, the Bureau will use its certification process at health centers and sites to determine the validity of data collected both in the UDS and from the User/Visit Survey. In establishing the data infrastructure for the management of chronic diseases, the Bureau will be able to obtain information to validate the data collected from the UDS and the User/Visit Survey.

The analyses of claims data on Medicaid beneficiaries at multiple sites beyond health centers also will be used to judge the validity of the information collected on health center users from this and other sources.

### **C. Performance Information on Data Sources**

The Bureau has used health center effectiveness studies, literature reviews, NHIS and NHAMCS results, and other special studies to develop baseline estimates. In some cases, the baseline estimates are not directly comparable. With an additional year of UDS data, the Bureau will be able to use its own trend data to benchmark its performance. With plans to launch the User/Visit Survey again in FY 2000, the Bureau will have comparative data to assess its measures of health status disparities. The Bureau is expanding and modifying the survey instrument to obtain critical information on measures of access to care and perceived functional capacity. The Bureau has used HP 2000/2010 targets to assess its program performance currently. Where performance has met or exceeded those targets, it has set new “stretch” targets to continuously improve performance.

The Bureau is currently developing its integrated management information system (MIS) to assure direct transmission of data to a central repository. This system will have edit checks and internal validation monitoring programmed into its components. This MIS will assist in assuring the validity of performance data collected.

### **D. Data Limitations**

Over the 1996-1998 period, UDS data have been collected from nearly 100% of health center grantees. The UDS contractor works closely with grantees to provide technical assistance when necessary to assure completeness of reports. Some grantees neglect to submit one or more specific tables, but the “N” for these tables has never been below 95% of the total number of grantees. Grantees need until February 15 to complete their reports. Preliminary table summaries are provided by early April and final table summaries by mid-June. This time frame has been necessary to assure the receipt of responses from all grantees and the completeness of each report. Program managers have stated that receipt of data by mid-June is barely sufficient to assist in important decision-making. The Bureau is making every effort to shorten these time frames. First, it will make virtually no changes in the FY 1999 tables so that grantees can become even more accustomed to format. Second, it will implement the electronic submission of reports and training of grantees in submission of reports in FY 1999. A pilot test of the electronic submission for health centers in Region X revealed significant reduction in errors in reports and less time spent on assuring completeness of the reports. The Bureau anticipates that program managers will receive table summaries in final form well before June for the FY 1999 collection.

Although the User/Visit Survey sample size is sufficiently sensitive to obtain National estimates, it is not robust enough to obtain substantial detailed information on subgroups of the minority user population.

The Bureau will conduct special surveys to “oversample” health centers and sites that are likely to provide this detailed information, consistent with the President’s Initiative on Race.

The Breakthrough series is a labor-intensive process where the Bureau anticipates that 100 sites will participate in the first year and that number will grow over the next 3-5 years. The Collaboratives use a “train-the-trainer” methodology to enhance the “spread” to other health centers and sites. Until Collaboratives are in place at all Bureau-supported sites, it will not be able to achieve its ultimate validation goals.

## **HIV/AIDS Data Collection Efforts**

### **(HIV/AIDS Bureau)**

#### **A. General Description of the Source/System**

HRSA’s HIV/AIDS Bureau is currently developing a data system in order to streamline and simplify reporting by Ryan White Care Act (RWCA) grantees while establishing a minimum set of data reporting requirements for all RWCA Title programs. This system is referred to as a cross-title data system.

The HAB Office of Science and Epidemiology (OSE) staff have been working with Titles I, II, III, and IV program representatives for the past year on the task of integrating the aggregate reports completed by RWCA grantees from Titles I-IV into one report form. Modifications have been made to the individual Titles’ data report forms in order to reduce reporting burden, standardize data collected across titles so RWCA programs can be examined as a whole, and to provide more detailed account of the types of clients served.

In its initial draft form, the revised cross-title prototype data collection form was composed of ten sections. These sections were constructed to gather grantee and provider-level information in the following areas:

Section 1: Ryan White Care Act Funding Streams and Administrative Services

Section 2: General Information about Grantees and Providers

Section 3: Program Specific Questions – Titles I and II

Section 4: Health Insurance, Income, and Other Demographic Information  
on Clients Receiving Ambulatory, Outpatient Medical Care

Section 5: Demographic Information about HIV+ Clients Receiving Other Services

Section 6: Title III Program Specific Questions

Section 7: Title IV Program Specific Questions

Section 8: AIDS Pharmaceutical Assistance Questions

Section 9: Health Insurance Continuation Program Questions

Section 10: Optional Client-Level Medical Care Outcome Measures

Through an external review, that included CARE Act grantees, HIV/AIDS National Groups such as the National Association of State and Territorial AIDS Directors (NASTAD), CDC, and HRSA Regional HIV staff, HAB is attempting to reach a consensus on what data elements are useful to collect in an aggregate reporting system as well as a consensus on how they will be used. OSE hopes to reach a consensus on how data should be collected and moved from providers through grantees to HRSA. OSE's approach will be to require aggregate reporting, using a revised cross-title report form, but encourage grantees to develop client-level reporting systems in order to capture the report information. The Bureau will offer technical assistance to all grantees that are willing to develop and maintain a client-level reporting system. The Bureau will offer grantees database software, RW CAREWare, for aggregate reporting of the new cross-title data as well as built in modules for their individual client-level data collections.

Two major issues have been integral to the external review. What data is absolutely necessary to collect through an aggregate reporting system and what could be collected through special studies or special sampling frames? A second draft is being prepared based on external input and will be piloted during the Spring/Summer 2000.

OSE also collects client-level data from a select group of eight grantees who have agreed to participate in demonstration projects for the purpose of collecting such data. The development of the client data set began in 1991, and implementation began in 1994. Development grew out of a desire to perform analyses on individuals rather than exclusively with summary data. The purpose of the client data set is to collect and analyze demographic information, health indicators, and service utilization data on individuals who receive services from providers who are funded by the RWCA.

RWCA grantees from 5 cities (Anaheim, CA; Los Angeles, CA; Middlesex, NJ; San Francisco, CA; and Washington, DC) and 3 states (California, Michigan, and Virginia) participate in the client level demonstration program. Providers collect intake and encounter data using prescribed data specifications from HAB and grantees receive the provider data, verify and unduplicated these data, and send the data set to HAB every 6 months. The greatest limitation of the client level data system is that the non-representativeness of the sites participating in these client-level data collection efforts limits the generalizability of their results. A competitive Request For Contracts will be let in Summer 2000 to establish a new group of participating sites that will be more geographically representative.

HRSA's HIV/AIDS Bureau also is collaborating with federal agencies on implementing health outcome measurement systems for HIV/AIDS. A joint CDC/HRSA effort is underway to improve the

usefulness of surveillance data for monitoring RWCA grantee performance. Currently, both agencies are conducting a joint pilot demonstration in four U.S. cities, the HIV/AIDS Care Sampling Pilot, to produce estimates of population parameters, with confidence intervals, of clinical outcomes for persons with HIV infection and /or AIDS. Variables to be collected include diagnoses of AIDS-defining opportunistic conditions, receipt of prophylactic treatments, and prescription of anti-retroviral medications. If these demonstrations are successful, nationwide implementation of this surveillance system will occur. The pilot stage will continue through the year 2000.

A joint AHRQ, SAMHSA, OPSE, and HRSA effort is funding a HIV Managed Care Association pilot study that collects medical resource utilization data by people living with HIV in 20 sites. Demographic, stage of illness, and treatment data are collected. The pilot is expected to result in a standard set of data elements for the 200 Association providers, most of who are RWCA funded, that reports on a regular basis real-time estimates of HIV medical resource use. This pilot effort is expected to continue through the year 2000.

While these large scale data collection efforts are being developed, HRSA is funding sentinel grantee sites to analyze existing multi-provider data sets for CARE Act related impact and outcome data. Studies focus on specific questions and specific populations, such as the impact of new treatments on perinatal transmission of HIV in selected Title IV sites and the impact of the provision of ancillary services on the entry into and retention in primary medical care. The non-representativeness of the sites participating in local evaluation studies limits the generalizability of their results.

## **B. Data Quality**

All grantees who receive funding from any of the Titles I, II, III, and IV will be asked to complete the cross-title data collection form according to their preferred format, i.e., completing a hard copy or completing the survey on the HAB website. All data will be sent to the data coordination contractor for OSE, who will be responsible for cleaning and editing the data and producing a correct master database for analysis by OSE employees. The overall data results will be reported on the HAB website and automated data reports will be mailed to all grantees. Data collected using the cross-title data collection instrument will provide measures of the numbers of clients served and types of services offered by each grantee and their provider network.

For all remaining data systems, providers collect intake and encounter data using prescribed data specifications from HAB and grantees receive the provider data, verify and unduplicated these data, and send the data set to HAB on a scheduled basis. Data edits checks are mandated by HAB for all data support contractors. Edit checks are completed for each grantee's original data submission and data verification reports are produced and mailed back to each grantee for verification. Only after the data from a given grantee has been verified through this process are the data included in the master database.

The client level data collection system now contains outcome measures that can be used to measure the extent to which services rendered using RWCA funds have produced desirable results. Variables to be collected include diagnoses of AIDS-defining opportunistic conditions, receipt of prophylactic treatments, and prescription of anti-retroviral medications. These measures are also a voluntary component of the new aggregate cross-title system. Our data collection contracts include validation of the data through edits and logic checks. We do not have IG or independent audits.

### **C. Performance Information on Data Sources**

HAB currently has valid data from grantees receiving funding from any of the RWCA title programs for 1996, 1997, and 1998. Data for FY 1999 will be available in January, 2001.

The client level data system will be expanding to include additional grantees starting in September, 2000. These grantees will be Title I and II sites who voluntarily agree to collect client level data and report the data to OSE on a scheduled basis.

### **D. Data Limitations**

Data reported as part of the cross-title system will be aggregate level data. One limitation of this type of data is the type of questions that can be answered using these data. For example, data from this system will provide the number of clients served by each grantee using RWCA funding; however, it is not possible to determine the exact number or combination of services received by each individual client. A second limitation is that the system contains duplicated data for clients, i.e., it is impossible to determine if an individual client received RWCA-funded services from more than one provider.

These types of limitations have been addressed, first, by giving grantees the option to participate in a client-level reporting system, which can address questions concerning the relationships across variables for individual clients. RWCA grantees who already collect or are willing to collect client-level data and submit it to HAB can compete for HAB funding to do so. HAB also funds special local evaluation projects to examine significant RWCA service issues.

## **Maternal and Child Health Reporting System**

### **(Maternal and Child Health Bureau)**

#### **A. General Description of the Source/System**

##### **Maternal and Child Health Bureau (MCHB) Block Grant**

In late 1997 the Maternal and Child Health Bureau (MCHB) completed an extensive collaborative effort with the States to re-engineer the Maternal and Child Health (MCH) Block Grant Annual Report and Application Guidance into a single process to meet requirements for State Block Grants under Title

V of the Social Security Act. As part of the effort, MCHB and the States built into the new guidelines the concept and reporting requirements for a Performance Partnership that introduced performance measurement to the Title V Block Grant program. The annual report and application submitted by each State now contains 18 standard performance measures which all States report, setting target values for each measure for a five-year period, and reporting annually on their actual performance. Similar targets, and performance levels, are reported on 6 standard outcome measures, and 7 to 10 additional specific measures set by each State. The data, contained in the annual report and application submitted each July, report achievements for the prior fiscal year, and set goals for the subsequent fiscal year.

#### MCHB Title V Discretionary Grants, Healthy Start Grants, and Emergency Medical Services for Children Grants

The Maternal and Child Health Bureau is taking the same approach used for the MCHB Title V Block Grant System to develop a system, or possibly systems, for MCHB Title V Discretionary Grants, Healthy Start Grants, and Emergency Medical Services for Children Grants. The process of setting the performance standards is already well under way with the Healthy Start program, where forms and data definition sheets have already been pilot-tested. In Emergency Medical Services for Children (EMSC), development is also well advanced, with initial testing completed. Clearance packages for OMB submission are in process. Development of performance measures for the Title V Discretionary Grant programs, including Special Projects of Regional and National Significance (SPRANS) and Community Integrated Services Systems (CISS), is now in process. The same type of automated data collection mechanism used in the Title V ERP is expected to be developed for each or all of these programs, and is planned to be operational by late Spring, 2000.

#### **B. Data Quality**

The actual collection and reporting of the data for the Annual Report and Application has been greatly simplified by the introduction, in early 1998, of an automated Title V Electronic Reporting Package (Title V ERP). The Title V ERP provides pre-formatted and interactive data entry that helps assure standardized data across States, and greatly simplifies the data entry process. All calculations (ratios, rates, percentages, as well as totals) are done automatically, tables are interlocked where data overlap, and historical data are preserved so that only the annual data for the year in question need to be newly entered. Required data must be entered before the ERP will transmit, and the system performs immediate checks for many common errors (out of range values, alpha entries in numeric fields, inverted ratios, etc.) Certain values which exceed statutory allowable limits trigger electronic flags, and open notation fields and/or require justification or waiver requests to be filed.

Great care was exerted in the development process to assure that performance measures are valid indicators for the specific concerns of the program. Detailed definition sheets were developed for each measure which address, among other things, the significance and relevance of each measure. The 7 to 10 specific measures developed by each State must meet the same requirements. All of the standard

measures relate to the overall objectives of the Title V program, while the State-specific measures relate to specific identified needs in each State, and the program interventions designed to address those needs.

### **C. Performance Information on Data Sources**

The first year of data was both useful, and a challenge. It marked the first time that there could be a single automated data set containing performance data on the MCH programs in all 59 States and Jurisdictions. It proved to be a challenging task to actually accomplish this. The data reported in the first year presented a number of difficulties. Not all States were able to report all required items, nor were they all reporting for the same time periods, nor were all items reported consistently for the same time period. Some data were estimated, some data were available only in alternate years, etc. Nevertheless, the data situation is far better than it was prior to the ERP: now the variations and variabilities are known, and clearly documented. In the second year, many States reported progress in obtaining needed data, and in a timely manner.

Some data, especially vital statistics data, have traditionally required extensive editing, at the case level, before totals and indices are considered reliable. For this reason, MCHB sometimes uses CDC data, instead of the more-current, but potentially less accurate data reported by the States, in developing its performance indices for this annual performance plan.

The ERP has largely proven itself, and is not in need of serious revision. Similarly, the data definition sheets have more than proven their value. A data reporting system, designed to make the large data set of State performance data available to policy makers and to the States, has been in testing, and has proven an incentive for increasing data quality. Preliminary analysis has helped clarify some of the differences between States,

### **D. Data Limitations**

As noted above, not all States had all required items available for the same uniform time periods, or even every year. MCHB has proposed an initiative to assist the States to develop and implement remedial steps to improve their data collection, tabulation, editing, analysis, dissemination, and use. This effort will be closely coordinated with the State MCH Directors to assure their data needs are met.

## **Health Professions**

### **(Bureau of Health Professions)**

#### **A. General Description of the Source/System**

The Bureau of Health Professions (BHP) has been working for several years to develop a systematic approach to collecting and measuring outcome performance data on the Bureau's Titles VII and VIII health professions and nursing education programs. At the core of the Comprehensive Performance Management System (CPMS) are cross-cutting outcome indicators which measure activities common to most programs and measure the aggregate effects of grantee achievements in support of the goal. The indicators are, in turn, associated with goals established by HRSA. The outcomes and indicators have been validated by representatives from health professions associations and leaders in health professions schools.

The Bureau is making steady progress in collecting data directly from its grantees to measure progress for all outcome areas associated with each cross-cutting goal. A CPMS demonstration project in 1998 showed that it would be both feasible and desirable to capture required performance information in a more streamlined manner. The first data from this project became available to us in December 1999 - just prior to preparation of the report.

The BHP is now developing an automated version of the CPMS data collection instrument. With the automated instrument each grantee will be able to access the data collection instrument from the BHP Web site, download the instrument to their computer, complete the form and send it back to BHP electronically. The requirements for the automated instrument, including the built-in edits, are based on findings from the demonstration project and an advisory group composed of representatives from grantee institutions. We expect to have the instrument available for automated collection of FY 2000 data by October 2000.

#### **B. Data Quality**

As indicated above, the BHP has worked for several years to develop, test and refine the CPMS, the data collection instruments and the editing standards and methods to be used during data input.

The first CPMS data collection from grantees was conducted in the first and second quarters of FY 1999 when each grantee downloaded a data collection instrument from the BHP Web site. The grantee then filled in the information by hand and mailed it to BHP. BHP personnel reviewed the data input tables contained in each report for completeness and internal consistency. The reviewer, for instance, were expected to perform range validation checks, check the summation of rows and columns and the calculation of percentages, and make comparisons between logically related fields. Those reports which did not meet the standards were returned to the program offices and program officers

contacted the grantee organization to make the necessary changes. Those reports which passed the edit checks, including those that were corrected after initial rejection, were sent to the contractor for data entry.

BHPr will use these methods to process the grantee reports for FY 1999 which will be submitted during the first and second quarters of FY 2000. The BHPr will, however, modify the tables and procedures based on lessons learned in the FY 1998 data collection activity.

The CPMS data, collected from all grantees as a condition for continuation of the grant, is enumerative. BHPr will use counts, sums and other basic descriptive statistics to analyze and report the data.

### **C. Performance Information on Data Sources**

The baseline data, going back to FY 1998, is composed of data collected from grantees prior to beginning the CPMS. Those performance data sources was compiled from program records, grantee applications and progress report.

### **D. Data Limitations**

BHPr initiated the CPMS in response to the need to improve data availability, quality and timeliness. It is recognized that the quality of CPMS can be no better than the quality of data submitted by grantees. As part of implementing Public Law 105-392, BHPR defined data requirements to be addressed in competitive grant applications. To emphasize the importance of high quality data, BHPr also is requiring organizations which submit applications for competitive grants beginning in FY 2000 to describe the methods and systems that will be used to accurately collect and submit CPMS and other performance data. Grantees with deficient systems are required to present a corrective action plan for getting them to an acceptable level.

During FY 2000 program officials will evaluate grantee data collection and reporting methods and the validity of CPMS data during technical assistance visits to grantees. BHPr program officials will compare CPMS data against data submitted by grantees in their competitive grant applications to determine if the data is reasonable in relation to data collected from other sources.

## **Rural Health**

### **(Office of Rural Health Policy)**

#### **A. General Description of the Source/System**

Beginning in 1992, the Office of Rural Health Policy began collecting project and population

information on its Rural Health Outreach program grantees during the annual grant review process. The data collected includes the primary focus of the project (e.g. case management, consumer health education, emergency care, etc.); an estimate of the time spent on the service; the percent of each population group (African American, American Indian, Asian/Pacific Islander/Alaska Native, Caucasian, Hispanic) served; and a numeric estimate of the population mix (e.g. adults, children, elderly, etc.), and information on project participants and other data.

In FY 1999 the Office revised the data collection form slightly for clarity and also added two questions, 1) to determine if the project serves an MUA or HPSA, and 2) to find out if the grantee is replicating a previously successful project. These efforts will provide short-term information on the program. Because the grant period is for only three years, long-range studies are not possible.

In addition, the Office has been working with a contractor to help in the decision making process in the selection of grantees. Toward this end, the contractor has identified the critical factors that contribute to the success or failure of service delivery models. These critical factors have been incorporated into the grant program guidance issued to potential applicants and are used in the evaluation of applications. In FY 1999 ORHP worked with the contractor to develop methods to better understand the value of outreach grants to rural communities and the impact on local services. The Office will also develop an information collection instrument/strategy that will be submitted to the Office of Management and Budget for approval in FY 2000.

## **A.2 Changes and Improvements Over Previous Year**

HRSA has made a number of improvements in the FY 2001 version of its Annual Performance Plan.

### Continued Improvement in Data Sources and Information

The agency has made a concerted effort to strengthen the level of data sources and information used to measure performance goals. This is an area that will require continuous attention. Many of these data issues are discussed above in the section on Approach to Performance Measurement. This also provides additional information on the data sources that are being utilized and progress made in improving data systems.

### Improved Linkage to Strategic Plans

HRSA has structured its performance goals for the FY 2001 Plan in the context of four strategies:

- Eliminate Barriers to Care
- Eliminate Health Disparities

- Assure Quality of Care
- Improve Public Health and Health Care Systems

Each performance goal is targeted to one of these four strategies, and is shown as such in the summary charts developed for each program activity.

In addition, since the final Strategic Plan of the Department of Health and Human Services was submitted to the Congress in the fall of 1997, HRSA has been better able to link its performance goals with the goals and objectives in that Strategic Plan. For each of the six HHS goals, HRSA has provided examples of program activity and FY 2001 performance goals. A matrix is included later in the Appendix which provides examples of this linkage. During the past year, HRSA has continued to work on a draft of its own Strategic Plan. The agency is continuing to receive input as to the structure and specificity of the objectives.

#### Review of Performance Goals

HRSA has continued to review its performance goals to determine opportunities for improvement. The performance goals for the Health Centers program, for example, have been expanded to include the extent to which National Health Service Corps physicians are retained in service to the underserved. The Health Center goals which relate to *Healthy People 2000* targets now show both the HP2000 target and the comparable Health Center target.

The Program Management performance plan includes new performance goals aimed at improved information technology management. These include goals to improve accessibility to the HRSA data warehouse; and to ensure critical infrastructure protection.

The Bureau of Health Professions has continued to refine its approach to integrating performance goals. In the first year of performance planning, individual performance plans were developed for each of some 26 health professions and nursing training programs. For 2001, the performance plans for these programs are integrated into one plan which is presented in terms of seven cross-cutting indicators. It focuses, for example, on the effect of all health professions programs on increasing diversity by increasing the number of minority/disadvantaged graduates and enrollees.

#### Focus on Evaluation

HRSA has included a discussion of how the evaluation program supports performance planning. This includes both efforts to utilize technical assistance and training to strengthen the Agency's capacity to assess program performance, and through individual studies to complement the data developed through monitoring systems related to GPRA. A discussion of the Evaluation Program is included later in the Appendix.

### A.3 Linkage to HHS and OPDIV Strategic Plans

As noted above, since the final Strategic Plan of the Department of Health and Human Services was submitted to the Congress in the fall of 1997, HRSA has been better able to link its performance goals with the goals and objectives in that Strategic Plan. For each of the six HHS goals, HRSA provides examples of program activity and FY 2001 performance goals. The matrix which follows provides examples of this linkage.

#### Illustration of HRSA Performance Goals that Support HHS Strategic Objectives

HHS Strategic Objective	HRSA Activity	FY 2001 HRSA Performance Goals
<b>Goal 1: Reduce the Major Threats to the Health and Productivity of all Americans</b>		
1.1: Reduce Tobacco Use, Especially among Youth	Primary Care: Health Centers	Performance goals aimed at reducing disparities, such as those focused on appropriate screening for cancer and control of hypertension, include efforts aimed at health education and health promotion for the target population (includes smoking cessation counseling).
1.2: Reduce the Number and Impact of Injuries	Maternal and Child Health: Emergency Medical Services for Children	Increase the number of States that require all EMSC-recommended pediatric equipment on Advanced Life Support Ambulances.
1.6: Reduce Unsafe Sexual Behaviors	Maternal and Child Health: Abstinence Education Programs	Reduce the rate of births to teenagers aged 15-17 in 50 percent of the participating States.
	Family Planning	Increase the number of individuals served by Title X (Family Planning) clinics.
	HIV/AIDS: HIV Pediatric Grants	Increase the number of enrolled female clients provided comprehensive services, including appropriate services before or during pregnancy, to reduce perinatal transmission.

HHS Strategic Objective	HRSA Activity	FY 2001 HRSA Performance Goals
<b>Goal 2: Improve the Economic and Social Well-Being of Individuals, Families and Communities in the United States</b>		
2.5: Increase Opportunities for Seniors to Have an Active and Healthy Aging Experience	Health Professions and Nurse Training Programs	Promote a health care workforce with a mix of the competencies and skills needed to improve access to cost-effective quality care.
<b>Goal 3: Improve Access to Health Services and Ensure the Integrity of the Nation's Health Entitlement and Safety Net Programs</b>		
3.1: Increase the Percentage of the Nation's Children and Adults who have Health Insurance Coverage	Maternal and Child Health Block Grant	<ul style="list-style-type: none"> <li>- Decrease the percent of children without health insurance.</li> <li>- Increase the percent of Children with Special Health Care Needs in the State program with a source of insurance for primary and specialty care.</li> </ul>
3.2: Increase the Availability of Primary Health Care Services	Primary Care: Health Centers	Increase the number of uninsured and underserved persons served by Health Centers, with emphasis on areas with high proportions of uninsured children in order to help implement the State Child Health Insurance Program.
	Primary Care: Health Centers	Assure access to preventive and primary care for low income individuals.
	Primary Care: Health Centers	Assure access to preventive and primary care for minority individuals.
	Primary Care: Health Centers and National Health Service Corps	Increase the field strength of the National Health Service Corps through scholarships and loan repayment agreements.
	Health Professions and Nursing Training Programs	Increase the number of faculty and trainees in settings serving underserved areas.

HHS Strategic Objective	HRSA Activity	FY 2001 HRSA Performance Goals
	Health Professions and Nursing Training Programs	Increase the number of minority/disadvantaged graduates and/or program completers.
	Rural Health: Rural Health Outreach	Develop and operate collaborative models of health care services in rural areas which will serve underserved populations.
	Rural Health: Rural Health Outreach	Network Development: Improve rural health care access by developing vertically integrated provider networks that will involve rural health providers.
	Maternal and Child Health Block Grant	Increase the percent of children with special health care needs in the State with a medical/health home.
	HIV/AIDS: HIV Early Intervention Services	Increase the number of people receiving primary care services under Ryan White Early Intervention Services programs.
3.3: Improve Access to and the Effectiveness of Health Care Services for Persons with Specific Needs	Maternal and Child Health Block Grant	Increase the percent of children with special health care needs in the State with a medical/health home.
	HIV/AIDS: HIV Emergency Relief Grants (Part A)	Increase the number of visits for health-related care to a level that takes account of new clients in the program.
	HIV/AIDS: HIV Care Grants to States (Part B)	Increase the number of visits for health-related care to a level that takes account of new clients in the program.
	HIV/AIDS: HIV Care Grants to States (Part B)	Increase the number of ADAP clients receiving appropriate antiretroviral therapy through State ADAPs during at least one month of the year.
<b>Goal 4: Improve the Quality of Health Care and Human Services</b>		
4.1: Promote the Appropriate Use of Effective Health Services	Health Professions and Nursing Training Programs	Promote a health care workforce with a mix of the competencies and skills needed to improve access to cost-effective quality care.

HHS Strategic Objective	HRSA Activity	FY 2001 HRSA Performance Goals
	Primary Care: Health Centers	Decrease the proportion of health center users who are hospitalized for potentially avoidable conditions (i.e., conditions sensitive to ambulatory care interventions).
4.2: Reduce Disparities in the Receipt of Quality Health Care Services	Primary Care: Health Centers	Performance goals aimed at reducing disparities in the areas of screening for cervical and breast cancer, hypertension, and diabetes.
	Health Professions and Nursing Training Programs	Promote a health care workforce with a mix of the competencies and skills needed to improve access to cost-effective quality care.
	Special Programs: Organ Procurement and Transplantation	Increase by 20 percent the number of minority organ donors nationally from implementation of the final HCFA Rule on Conditions of Participation.
<b>Goal 5: Improve Public Health Systems</b>		
5.1: Improve Public Health Systems' Capacity to Monitor the Health Status and Identify Threats to the Health of the Nation's Population	Health Professions and Nursing Training Programs	Promote a health care workforce with a mix of the competencies and skills needed to improve access to cost-effective quality care.
<b>Goal 6: Strengthen the Nation's Health Sciences Research Enterprise and Enhance its Productivity</b>		
6.4: Increase the Understanding of and Response to the Major Issues Related to the Quality, Financing, Cost and Cost-Effectiveness of Health Care Services	Rural Health: Rural Health Policy Development	Rural Health Research Grant Program: To conduct and disseminate policy relevant research studies in each of ORHP's rural research centers, with a particular focus on the implications of the Balanced Budget Act of 1997.

## **A.4 Performance Measurement Linkages with Budget, Human Resources, Cost Accounting, Information Technology, Capital Planning and Program Evaluation**

### **Budget**

In the FY 2001 HRSA budget, performance measurement is linked with every significant program element for which funding is requested. As required by statute, the HRSA budget proposals incorporate performance measures which attempt to gauge and identify the outcomes and benefits to be achieved by the implementation of the program increments. It is expected that the inclusion of performance measurements in annual funding requests will enable the Congress and Executive Branch policy-makers to assess the value and success of HRSA's programs in the context of national priorities and benefits to the American people.

### **Human Resources**

HRSA has devoted a considerable effort to workforce planning. An analysis was conducted on the requirements for and distribution of FTE's, both in headquarters and in the field offices. This has led to a redistribution of positions and to a recognition that staff resources will need to be enhanced in certain growing program areas.

HRSA has also provided strong support for the Quality of Work Life (QWL) Initiative. HRSA's plan is divided into three (3) sections: Employee Development; Employee Health and Fitness; and Workplace Improvement. To implement the plan, HRSA appointed a QWL Implementation Team, with representation from headquarters and the field. The work of the Implementation Team was conducted within 3 sub-groups, which focused on the 3 subject areas. A major focus is on increasing investment in workplace learning. Through the HRSA Career Resources Center, employees have access to workshops, printed materials and computer programs which increase their participation in workplace learning. The CRC staff is continuing to develop workshops to address the issues identified in the Training Needs Assessment, including leadership, coaching, time management, and mentoring. Through a contract with Loyola College, HRSA gives employees the opportunity to participate in classroom instruction designed to enhance their job skills and knowledge. HRSA is also offering a number of special opportunities across the Agency including Master of Business Administration (MBA) programs and women's leadership programs.

### **Cost Accounting**

HRSA produces financial statements for each of its six major GPRA program areas: Primary Care, Health Professions, Maternal and Child Health, HIV/AIDS, the Office of Special Programs and Rural Health. In addition, statements are produced for Family Planning and Bureau of Prisons activities which are financially under HRSA but are located in other organizations. The statements report financial position and the net cost of operations and are based on accounting records maintained for HRSA by the Program Support Center.

Cost accounting is an important tool for decision-makers in assessing the value and potential of budget increments and program initiatives.

### **Information Technology**

As a by-product of HRSA's capital planning efforts, the Office of Information Technology has developed a HRSA IT investment portfolio comprised of all information technology initiatives, systems, and other IT investments. The planning document, "HRSA Information Technology Investments," details the major systems, mission-critical systems, Presidential Decision Directive 63, and all other IT systems or initiatives, including ongoing initiatives, that HRSA has planned through Fiscal Year 2001. The IT portfolio will be used to identify any performance gap between existing capabilities and objectives highlighted in the strategic plan.

### **Capital Planning**

Following the legislative requirements and guidance for capital planning addressed in the GPRA and the Clinger-Cohen Act (CCA) of 1996, HRSA is challenged to make technology decisions in a business context to ensure an acceptable return on investment (ROI) and direct linkage to the department's mission and strategic objectives.

In 1997, HRSA established an Information Technology Board (ITB) to develop a capital planning and investment review process which meets the requirements of CCA, and standardize the information requirements for review and approval of information technology (IT) investments. The ultimate goal of the ITB is to assist HRSA in making better IT decisions that measurably improve organizational performance.

By Fiscal Year 2001, HRSA will implement an information system to track IT projects and increase linkage to the expenditure of funds. HRSA is currently evaluating the Information Technology Investment Portfolio System (ITIPS); a system which is supported by the Federal Chief Information Officer (CIO) Council. The "ideal" tracking system is one that will capitalize on agency-specific linkages between IT capital planning and other processes such as investment planning, budgeting, and procurement execution.

### **Program Evaluation**

The purposes of the Health Resources and Services Administration (HRSA) evaluation program are to enhance strategic and performance planning and reporting, strengthen budget and legislative development, and improve program management. HRSA's evaluation priorities are to (1) develop and support performance measurement, (2) evaluate program effectiveness and impact, (3) assess program implementation, and (4) conduct crosscutting policy analysis, such as environmental assessments.

Performance measurement includes technical assistance and training to strengthen the agency's capacity to respond to the requirements of the Government Performance and Results Act (GPRA), and to lay a foundation for assessing program performance over time. In 1995, HRSA completed a study that established a performance measurement baseline for all operating programs, using a common framework to develop program-specific logic models. HRSA has invested substantial funding over the past four years to provide technical assistance tailored to the needs of individual agency programs. These efforts have been focused on (1) assisting with identification of indicators and measures and development or refinement of data systems; and (2) helping HRSA components to enhance their capacity to plan for, collect, analyze and use the performance information submitted by grantees for program management as well as for preparing GPRA-related documents. One result of this technical assistance was a partnership between the Maternal and Child Health Bureau (MCHB) and the States to develop a set of standard performance measures for the Maternal and Child Health Block Grant that are now being used by MCHB and the States in goal setting, performance reporting, and performance monitoring. Building on these program-specific efforts, work began in 1998 to link the HRSA strategic plan, annual performance plans and budgets through a set of HRSA-wide performance strategies: eliminate barriers to care; eliminate health disparities; assure quality of care; and improve public health and health care systems. An ongoing project, *Crosscutting HRSA-Wide Performance Strategy*, has supported this effort.

Program effectiveness studies assess intermediate and longer-term outcomes or impact of programs in relation to their intended goals. For example, the *Impact of Community Health Workers on Access, Use of Services and Patient Knowledge and Behavior* showed that use of community health workers in HRSA-funded programs led to increased access to care for patients, and to increased knowledge of nutrition and other topics to promote a healthy lifestyle. The ongoing study *Effectiveness of the National Health Service Corps* is assessing the program over time, using retention in primary care and related professions as one measure of effectiveness. The *National Evaluation of the Healthy Start Program*, also ongoing, is a multi-year study with both outcome and process components. The final report will present findings on the impact of the program on infant mortality and birth outcomes in Healthy Start sites, compared with matched comparison communities. The final report of the process component, *The Implementation of Healthy Start: Lessons for the Future*, is included among studies completed in FY 1998. Another ongoing project, *Comparison of Services Received and Health Outcomes for Persons Funded by the CARE Act and by Other Sources*, compares demographic characteristics, services needed and provided, and health outcomes between persons receiving CARE Act-funded services and the general treatment population. Finally, the current study, *Employment Sites of Nursing Graduates Supported by the Professional Nurse Traineeship Program*, is assessing the impact of a funding preference in the grants process on the achievement of the program objective of increasing access to care in underserved communities.

Environmental assessment concerns the ways in which forces in the larger society affect HRSA programs or progress toward achieving crosscutting goals and objectives. For example, the ongoing

project *Managed Care and Safety Net Providers* is examining the impact of Medicaid managed care and other changes in health care coverage on the future viability of safety net providers operating in primary care settings, including grantees of HRSA-funded programs such as Community Health Centers. A completed study, *Pacific Partnerships for Health: Charting a New Course for the 21st Century*, outlines health status and access issues for the populations of six island jurisdictions and recommends approaches for improvements. Findings from a current project, *A Pilot Study to Identify Infrastructure Building Across HRSA Programs*, will improve HRSA's understanding of the interaction and effects of its programs in the context of health system changes and shifting population needs.

Program management studies provide information for developing and implementing a program.

The completed study, *Data Collection and Budget Forecasting Strategies: A Primer for State AIDS Drug Assistance Programs*, produced a primer that will enable the State-administered AIDS Drug Assistance Programs to estimate their expenditures more accurately and, consequently, administer the federal funds more efficiently. The *Strategies for the Recruitment, Retention, and Graduation of Hispanics into the Baccalaureate Level of Nursing*, developed a model that can be used by institutions of higher education seeking to increase the proportion of Hispanic Americans admitted to baccalaureate programs as their initial entry into nursing education.

In addition, HRSA supports activities to enhance the quality of evaluation agencywide, such as by funding short courses in evaluation for staff, encouraging presentation of HRSA studies at national conferences, and expanding the capacity of agency staff to provide skilled technical assistance on the framing, design and implementation of studies. Broadening of dissemination of study products through a variety of electronic and other approaches also will continue to be a priority through 2001.

## HEALTH RESOURCES AND SERVICES ADMINISTRATION

### A. 5. COMPARISON OF ORIGINAL FY 2000 TARGETS WITH REVISED FY 2000 TARGETS

Performance Measure	Original FY 2000 Targets	Revised FY 2000 Targets
<p>Health Centers, I.A.1.</p> <p>Increase the number of uninsured and underserved persons served by Health Centers, with emphasis on areas with high proportions of uninsured children to help implement the SCHIP program.</p>	9,025 million served	<p>9.6 million served</p> <p>Due to increased funding in FY 2000.</p>
<p>National Health Service Corps I.B.1.</p> <p>Increase the field strength of the National Health Service Corps through scholarships and loan repayment agreements.</p>	Field strength: 2,426	<p>Field strength: 2,697</p> <p>Due to reestimate of obligated individuals</p>
<p>National Hansen's Disease Program, I.A.1.</p> <p>Provide residential care for the current HD residential patients at Carville.</p>	75 patients	<p>52 patients</p> <p>The original estimate for FY 1999 was that 80 patients would be involved in this option. The actual performance for FY 99 was 60 patients. This is due to a higher degree of acceptance of the option to receive an assisted living allowance and to live independently.</p>

<b>Performance Measure</b>	<b>Original FY 2000 Targets</b>	<b>Revised FY 2000 Targets</b>
<p>National Hansen's Disease Program, I.A.2</p> <p>Provide payment of assisted living allowances for those long-term residential patients willing and able to live independently.</p>	50 patients	<p>59 patients</p> <p>The original estimate for FY 1999 was that 46 patients would accept this option. The actual FY 99 performance was 60 patients. The estimate for FY 2000 reflects this initial higher level of acceptance of stipends than originally projected.</p>
<p>Federal Occupational Health Program, I.B.1,</p> <p>Clinical Services: Provide needed basic clinical services to Federal employees.</p>	352,000 served	<p>212,000 served</p> <p>FY 00 target is based on actual FY 99 performance of 198,000. The actual performance level is stated in terms of the federal population covered by FOH clinical agreements for the basic, standard package of services.</p>
<p>Federal Occupational Health Program, I.B.2</p> <p>Environmental Health Services: Increase the number of specific environmental services provided.</p>	29,000 services provided	<p>32,600 services provided</p> <p>Based on current data, we think that the FY 00 estimate is higher than earlier proposed. Projected levels are based on the volume of current business, marketing efforts, and trends such as agency budget pressures, competitors' successes, and downsizing.</p>
<p>AIDS:HIV Emergency Relief Grants, Part A, I.B.1</p> <p>Increase the number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative and home health) to a level that approximates inclusion of new clients.</p>	2.97M	<p>2.92M</p> <p>The FY2000 Performance Goal was modified from the FY 1999 goal to include the HAB's complete definition of medical care, thus, not only primary medical care per the FY 1999 goal but also other services as listed above. FY 2000 target has been revised to reflect a more accurate baseline figure for 1998.</p>

Performance Measure	Original FY 2000 Targets	Revised FY 2000 Targets
<p>AIDS:HIV Care Grants to States, Part B, I.B.1</p> <p>Increase the number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative and home health) to a level that takes account of new clients in the program.</p>	1.23M	<p>1.53M</p> <p>The FY2000 Performance Goal was modified from the FY 1999 goal to include the HAB's complete definition of medical care; thus, not only primary medical care per the FY 1999 goal but also other services as listed above. FY 2000 target has been revised to reflect a more accurate baseline figure for 1998.</p>
<p>AIDS:HIV Care grants to States, Part B, II.B.1</p> <p>Increase the number of ADAP clients receiving appropriate antiretroviral therapy (consistent with clinical guidelines) through State ADAPs during at least one month of the year.</p>	82,200 clients	<p>74,500 clients</p> <p>The goal for FY 2000 has been revised to reflect a more accurate tracking mechanism.</p>
<p>AIDS:HIV Early Intervention Services, I.A.1.</p> <p>Increase the number of people receiving primary care services under Early Intervention Services programs.</p>	100,433 clients	<p>110,398 clients</p> <p>Revised based on the Early Intervention Program's successful performance (i.e., in excess of its FY 99 target).</p>
<p>AIDS:HIV Early Intervention Services, II.B.1.</p> <p>Increase the number of racial and ethnic minorities who are receiving primary care services under Early Intervention Programs.</p>	68,300 (68%)	<p>77,279 (70%)</p> <p>Revised based on the Early Intervention Program's successful performance (i.e., in excess of its FY 99 target).</p>

Performance Measure	Original FY 2000 Targets	Revised FY 2000 Targets
<p>AIDS:HIV Pediatric Grants (Women, Children &amp; Youth), III.B.1</p> <p>Decrease 5 percent the number of newly reported AIDS cases in children as a result of perinatal transmission.</p>	395 cases	<p>203 cases</p> <p>Revised performance targets were developed for this indicator by applying the five percent annual decrease in newly reported pediatric AIDS cases from the original goal to the actual FY 98 performance of 225 cases based on the updated data source for measuring this indicator.</p>
<p>AIDS: Dental Services Program, III.A.1.</p> <p>Increase the number of persons for whom a portion of their unreimbursed oral health costs were reimbursed.</p>	67,000 persons	<p>46,000 persons</p> <p>Revised based on improved data source.</p>
Health Professions and Nursing Training Programs	Targets included for 6 performance goals	Targets revised based on changes in funding levels and improvements in data sources.
<p>NPDB and HIPDB, III.B.1</p> <p>Increase the use of NPDB and HIPDB for decision-making by queries.</p>	<p>3,300,000 queries</p> <p>11,100decisions</p>	<p>4,000,000q</p> <p>13,350d</p> <p>HIPDB (New)</p> <p>700,000q</p> <p>700d</p> <p>The performance target for FY 00 was increased by 21% to reflect the trend in actual performance. New performance target is presented for the HIPDB, a program that began operation in FY 00.</p>

<b>Performance Measure</b>	<b>Original FY 2000 Targets</b>	<b>Revised FY 2000 Targets</b>
Organ Procurement and Transplantation, I.C.1. Increase by 20% over two years the number of organ donors nationally from implementation of the final HCFA Rule on Conditions of Participation of Hospitals.	6,900	6,589  FY 00 target has been revised to reflect more complete data now available.
Organ Procurement and Transplantation, II.B.1. Increase by 20% over two years the number of minority organ donors nationally from implementation of the final HCFA Rule on Conditions of Participation of Hospitals.	1650	1638  FY 00 target has been revised to reflect more complete data now available.
National Bone Marrow Donor Program, I.C.1 Increase by 7.5% the number of unrelated bone marrow donors (national registry of potential donors) over previous year totals.	3.12M donors	4.02M donors  FY 00 target has been revised to reflect more complete data now available on donor recruitment in recent years.
National Bone Marrow Donor Program, II.B.1 Increase by 10% the number of unrelated minority bone marrow donors (national registry of potential donors) over previous year totals.	242,000 minority donors	1,000,000 minority donors  FY 00 target has been substantially revised to reflect that the original number measured new donors, not total, as well as more complete data now available on donor recruitment in recent years which shows the effect of targeting minority donors.
Rural Health Outreach, I.A.1. Number of clients served by rural models.	720,000 clients	764,000 clients Based on increased funding.

Performance Measure	Original FY 2000 Targets	Revised FY 2000 Targets
State Offices of Rural Health, I.A.1. States which have implemented performance measurement indicators.	50 state offices	32 state offices  Improved tracking system.
Telehealth, I.A.1 Evaluate telehealth programs in urban communities which are designed to overcome barriers to health care for underserved individuals.	10 grants/25,000 served	NA: 0 Grants  Funding limited to rural projects only. In the FY 2001 budget, a limited urban initiative is proposed.
Telehealth, IV.A.1 Complete evaluation of rural telemedicine grant program and publish findings.	Final report from encounter study, findings from cross-sectional survey, and 3 papers submitted for publication.	Draft survey package submitted to OMB; data collection completed; meta analysis from ongoing individual program evaluations completed.  The encounter survey was originally to be conducted in FY99, but changes in the actual practice of telemedicine required a complete revamping of the data collection forms, including the development of special forms to document mental health and emergency medical consultations, as well as consultations provided during telemedicine "specialty clinics." As a result, the OMB package for approval of the data collection instruments will not be submitted until Spring, 2000. This will delay data collection and the final report.

Performance Measure	Original FY 2000 Targets	Revised FY 2000 Targets
<p>Title X-Family Planning, I.A.1</p> <p>Increase the number of service demonstration models in the family planning program focusing on underserved populations, including males, adolescents, substance abusers, incarcerated populations, and the homeless.</p>	<p>Male Projects: 20</p> <p>Adolescent Projects: 15</p> <p>Substance Abuse: 3</p> <p>Incarcerated Grants: 7</p>	<p>Male Projects: 15</p> <p>Adolescent Projects: 8</p> <p>Substance Abuse: 1</p> <p>Incarcerated Grants: 3</p> <p>Based on current data, the estimate for FY 00 for both the Male and Adolescent projects is revised.</p>
<p>Title X - Family Planning I.C.1.</p> <p>Increase the number of individuals served by Title X clinics.</p>	<p>6.5M</p>	<p>5.25M</p> <p>The goal statement has been revised to reflect all clients served in the program, not just women in the clinic setting. In FY 2001, the program is requesting additional resources to more adequately address the need for expanded service provision. The estimated targets have been revised to reflect more realistically the fact that the overall number of clients nationwide has remained stable in recent years and is not expected to increase without targeted resources.</p>
<p>Program Management IV.C.1</p> <p>Assure that all HRSA systems are Y2K compliant.</p>	<p>18 systems</p>	<p>14 systems</p> <p>Several systems were retired and are not included in the revised estimate.</p>